REHABILITATION SERVICES AND CLAIMS MANUAL

VOLUME I

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Province of British Columbia

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Workers and Workplaces
Safe and Secure from Injury and Disease

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PREFACE

Section 82 of the *Workers Compensation Act* provides that the Board of Directors of the Workers' Compensation Board must set and revise as necessary the policies of the Board of Directors, including policies respecting compensation, assessment, rehabilitation and occupational safety and health (or prevention).

The policies of the Board of Directors consist of:

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

as well as amendments to policy in the four policy manuals, any new or replacement manuals issued by the Board of Directors, any documents published by the Workers' Compensation 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.

The *Manual* in which this preface appears (*Rehabilitation Services & Claims Manual*, Volume I) contains current Board policy with respect to the rehabilitation and compensation matters described in Chapter 1 of the *Manual*. It is used by Board staff in carrying out their responsibilities under the *Workers Compensation Act*. As new policy is developed and approved in this area, the *Manual* will be updated by issuing replacement pages.

[1] Decisions No. 1 – 423 are gradually being consolidated into the policy manuals, as appropriate, and "retired". An explanation of "retirement" and an index of "retired" Decisions are found in APPENDIX 1 to this *Manual*.

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CHAPTER 1

SCOPE OF VOLUME I OF THIS *MANUAL*

#1.00 INTRODUCTION

In 2002, the *Workers Compensation Act* underwent significant legislative amendment. This resulted in the restructuring of the *Rehabilitation Services & Claims Manual* into two volumes - Volume I and Volume II. This policy sets out an overview of the legislative changes and explains how readers of this *Manual* can determine which volume is applicable to their particular circumstances.

#1.01 Legislative Amendments

(a) *Workers Compensation Amendment Act, 2002* ("*Amendment Act, 2002")*

The *Amendment Act, 2002* is also referred to as "Bill 49". It primarily amended the *Workers Compensation Act:*

- effective June 30, 2002 in relation to benefits for injured workers (including the calculation of average net earnings, duration of temporary benefits, integration of CPP disability benefits, indexing of compensation benefits, worker obligations to provide information, mental stress and permanent disability awards); and
- effective January 2, 2003 in relation to the establishment of a new Board of Directors as the governing body of the Workers' Compensation Board.

(b) *Workers Compensation Amendment Act (No. 2), 2002* ("*Amendment Act (No. 2), 2002*")

The *Amendment Act (No. 2), 2002* is also referred to as "Bill 63". It primarily amended the *Workers Compensation Act* effective March 3, 2003 in relation to a new review/appeal structure and to the Board's authority to reopen matters previously decided or to reconsider previous decisions.

#1.02 Scope of Volume I and Volume II of this Manual

The *Rehabilitation Services & Claims Manual* was restructured into two volumes to facilitate the implementation of the new benefits policies resulting from the *Amendment Act, 2002*. The new policies were incorporated into Volume II, and the policies in place immediately prior to June 30, 2002 became Volume I. (For policies in effect prior to the Volume I policies, readers are referred to the Board's archives.)

Volume I and Volume II apply to different groups of injured workers. Whether the benefits for an injured worker are to be determined under Volume I or Volume II depends upon the transitional rules set out in policy item #1.03 below. It is the responsibility of decision-makers to determine whether Volume I or Volume II applies to each case before them.

Due to the fact that Volume I covers a finite group of injured workers, its relevance to the workers' compensation system will gradually decrease over time. It is anticipated that there will be very few future amendments to the policies in Volume I. Any major amendments will be listed, for convenience, in the Addendum to this chapter.

Volume II includes injuries occurring on or after June 30, 2002. Its relevance to the workers' compensation system will therefore continue over time. Volume II policies will be subject to amendment from time to time, in the same manner as policies in other policy manuals. Amendments to policies in Volume II will be archived in the Board's records and documented publicly.

#1.03 Scope of Volumes I and II in Relation to Benefits for Injured Workers

(a) General

Subject to subsequent amendments, Volume I sets out the law and policies that were in effect immediately prior to June 30, 2002 in relation to compensation for injured workers. For convenience, the law and policies in effect immediately prior to that date, as amended, will be called the "former provisions".

Volume II sets out the law and policies in effect on or after June 30, 2002, as they may be amended from time to time, in relation to worker benefits. For convenience, the law and policy on or after that date, including any subsequent amendments, will be called the "current provisions".

Except as otherwise stated and except in relation to matters covered by the *Amendment Act (No. 2), 2002*, in Volume I "*Act*" refers to the *Workers*

Compensation Act, as it read immediately before June 30, 2002. The *Interpretation Act*, RSBC 1996, Chapter 238, applies to the *Act*, unless a contrary intention appears in either the *Interpretation Act* or the *Act*.

(b) *Amendment Act, 2002* (Bill 49) Transitional Provisions

The following rules apply to determining whether the former provisions (Volume I) or the current provisions (Volume II) apply in a particular case. These rules are based upon the transitional rules in section 35.1 of the *Workers Compensation Act*, as amended by the *Amendment Act, 2002*.

1. Except as noted in rules 3, 4, and 5, the former provisions apply to an injury that occurred before June 30, 2002.

2. The current provisions apply to an injury that occurs on or after June 30, 2002.

3. Subject to rule 4 respecting recurrences, if an injury occurred before June 30, 2002, but the first indication that it is permanently disabling occurs on or after June 30, 2002, the current provisions apply to the permanent disability award with two modifications:

   (i) 75% of average earnings (former provisions) is used for calculating the award rather than 90% of average net earnings (current provisions); and

   (ii) no deduction is made for disability benefits under the Canada Pension Plan (former provisions).

   Under this rule, for an injury that occurred before June 30, 2002, where the first indication of permanent disability also occurs before June 30, 2002, the permanent disability award will be adjudicated under the former provisions. Where the first indication of permanent disability is on or after June 30, 2002, the award will be adjudicated under the current provisions, using the modified formula described in (i) and (ii) above. The determination of when permanent disability first occurs will be based on available medical evidence.

   An example of when this rule applies is where a worker, injured before June 30, 2002, shows no signs of permanent disability before that date. However, on or after June 30, 2002, the worker has surgery, which first causes permanent disability. The permanent disability award will be adjudicated under the current provisions, using the modified formula.

4. If an injury occurred before June 30, 2002, and the disability recurs on or after June 30, 2002, the current provisions apply to the recurrence.

   This transitional rule applies only to a recurrence of a disability on or after June 30, 2002. It does not apply to permanent changes in the nature and degree of a worker's permanent disability. Where a worker was entitled to a permanent disability award before June 30, 2002 in respect of a compensable injury or disease, the former provisions apply to any changes in the nature and degree of the worker's permanent disability after that date.

   For the purposes of this policy, a recurrence includes any claim that is re-opened for an additional period of temporary disability, regardless of whether the worker had been entitled to a permanent disability award before June 30, 2002. However, where the worker was entitled to a permanent disability award before June 30, 2002, the former provisions apply to any changes in the nature and degree of the worker's permanent disability following an additional period of temporary disability.

   The following are examples of a recurrence:

   - A worker totally recovers from a temporary disability resulting in the termination of wage-loss payments. Subsequently, there is a recurrence of the disability and the claim is re-opened for compensation.

   - A worker is in receipt of a permanent partial disability award and the disability subsequently worsens so that the worker is temporarily totally disabled. The claim is re-opened to provide compensation for a new period of temporary disability. The additional period of temporary disability is a recurrence to which the current provisions apply. However, a subsequent change in the nature and degree of the worker's permanent disability is adjudicated under the former provisions.

5. Regardless of the date of injury or death, the current provisions on indexing apply to compensation paid on or after June 30, 2002. Indexing of retroactive awards payable before June 30, 2002, will be based on the former provisions.

EFFECTIVE DATE: August 1, 2006
APPLICATION: Amendments to policy item #1.03(b)(4) that took effect on August 1, 2006 apply to all decisions, including appellate decisions, made on or after October 16, 2002.

HISTORY: June 17, 2003 – Reorganization of format and addition of content to address the scope of Volumes I and II of the Manual.
Amendments to transitional rule 4 in policy item #1.03(b) reflect the status quo by inserting the policy on the meaning of "recurrence" in section 35.1 of the *Act* that was previously approved effective October 16, 2002, and only inserted into Volume II.

#1.10 The Persons Covered by the *Act*

Not everyone is entitled to compensation under the *Act*, even if injured at work. To qualify for compensation, a person must be a "worker" employed by an employer covered by the *Act*. (1) Where a compensable injury or disease results in the worker's death, certain of the worker's relatives are entitled, but they must usually have been "dependants" during the worker's lifetime. (2)

#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.

#2.20 Application Of The *Act* And Policies

In making decisions, Board officers must take into consideration:

1. the relevant provision or provisions of the *Act*;

2. the relevant policy or policies in this *Manual*; and

3. all facts and circumstances relevant to the case.

By applying the relevant provisions of the *Act* and the relevant policies, Board officers ensure that:

1. similar cases are adjudicated in a similar manner;

2. each participant in the system is treated fairly; and

3. the decision-making process is consistent and reliable.

Section 99(2) of the *Act* provides that:

> The Board must make a decision based upon the merits and justice of the case, but in so doing the Board must apply a policy of the board of directors that is applicable in the case.

In making decisions, Board officers must take into account all relevant facts and circumstances relating to the case before them. This is required, among other reasons, in order to comply with section 99(2) of the *Act*. In doing so, Board officers must consider the relevant provisions of the *Act*. If there are specific directions in the *Act* that are relevant to those facts and circumstances, Board officers are legally bound to follow them.

Board officers also must apply a policy of the Board of Directors that is applicable to the case before them. Each policy creates a framework that assists and directs Board officers in their decision-making role when certain facts and circumstances come before them. If such facts and circumstances arise and there is an applicable policy, the policy must be followed.

All substantive and associated practice components in the policies in this *Manual* are applicable under section 99(2) of the *Act* and must be followed in decision-making. The term "associated practice components" for this purpose refers to the steps outlined in the policies that must be taken to determine the substance of decisions. Without these steps being taken, the substantive decision required by the *Act* and policies could not be made.

References to business processes that appear in policies are only applicable under section 99(2) of the *Act* in decision-making to the extent that they are necessary to comply with the rules of natural justice and procedural fairness. The term "business processes" for this purpose refers to the manner in which the Board conducts its operations. These business processes are not intrinsic to the substantive decisions required by the *Act* and the policies.

If a policy requires the Board to notify an employer, worker, or other workplace party before making a decision or taking an action, the Board is required to notify the party if practicable. "If practicable" for this purpose means that the Board will take all reasonable steps to notify, or communicate with, the party.

This policy item is not intended to comment on the application of practice directives, guidelines and other documents issued under the authority of the President/Chief Executive Officer of the Board. The application of those documents is a matter for the President/CEO to address.

EFFECTIVE DATE: March 3, 2003
APPLICATION: To all adjudication decisions made on or after the effective date

ADDENDUM

AMENDMENTS TO VOLUME I ON OR AFTER JUNE 30, 2002

This Addendum lists the major amendments to the policies in Volume I of the *Rehabilitation Services & Claims Manual* on or after June 30, 2002. It has been inserted for convenience only and will be updated by the Vice-President of the Policy and Research Division as necessary. In some cases, the reader may be referred to the appropriate passages in Volume II.

The "resolutions" referenced in this Addendum are the "resolutions" of the former Panel of Administrators or Board of Directors, as the case may be.

Subject	Policy or Item #	Comments
CPI Adjustments	Various	Except for policy item #56.50, the dollar amounts in Volume I are not updated to reflect CPI adjustments. Readers should consult the corresponding policy item in Volume II for the current amount. (Policy item #56.50 does not appear in Volume II and is therefore updated in Volume I.)
Criteria for Commutations	#45.00 - #45.60	Policies amended effective October 1, 2002. Amendments apply to new claims received, all active claims awaiting an initial permanent disability award adjudication, and all active claims awaiting initial adjudication of periodic payments of compensation to a dependant of a deceased worker, on or after the effective date. See resolution 2002/08/27-04 if more information is required.
Chronic Pain (or Subjective Complaints)	#22.33, #22.35, #39.01, #97.40	Policies amended effective January 1, 2003. Amendments apply to all new claims received and all active claims awaiting an initial adjudication on or after the effective date. See resolution 2002/11/19-04 if more information is required.

Subject	Policy or Item #	Comments
Governance	Various consequential changes	Policies amended effective February 11, 2003 to reflect January 2, 2003 changes to the WCB's governing structure. (None of the amendments affect worker benefits.) See resolution 2003/02/11-05 if more information is required. These amendments resulted from the *Amendment Act, 2002* (Bill 49).
New Review/ Appeal Structure	New Chapter 13 Various consequential changes	Chapter 13 (Appeals) deleted and new Chapter 13 (Reviews and Appeals) adopted effective March 3, 2003. Certain policies continued for transitional purposes. Various consequential changes made throughout Volume I, as identified by March 3, 2003 effective date and the matters to which the effective date applies. See resolution 2003/01/21-01 if more information is required. These amendments resulted from the *Amendment Act (No. 2), 2002* (Bill 63).
Policy on Changing WCB Decisions	New Chapter 14 Various consequential changes	Chapter 14 (Reopenings and Reconsiderations) deleted and new Chapter 13 (Changing Previous Decisions) adopted effective March 3, 2003. Chapter applies to all decisions on and after the effective date. Various consequential changes also made throughout Volume I, as identified by a March 3, 2003 effective date and the matters with respect to which the effective date applies. See resolution 2002/12/17-02 if more information is required. These amendments resulted from the *Amendment Act (No. 2), 2002* (Bill 63).

Subject	Policy or Item #	Comments
Binding Nature of Policy	#2.20, #96.10	New policy item #2.20 adopted effective March 3, 2003. Amendments apply to all adjudication decisions made on or after the effective date. Material also deleted from policy item #96.10 to reflect the amendments. See resolutions 2002/12/17-02 and 2003/01/21-01 if more information is required. These amendments resulted from the *Amendment Act (No. 2), 2002* (Bill 63).
Other Amendments Resulting from the *Amendment Act (No.2), 2002* (Bill 63)		
Pension Reviews	#40.30	Policies deleted effective March 3, 2003.
Provisional Rates	#66.12	Policies amended effective March 3, 2003. Policy applies to provisional rates set on or after the effective date.
Penalties for Failure to Report	#94.15	Policies amended effective March 3, 2003.
Preliminary Determination (Formerly Interim Adjudication)	#96.21	Policies amended effective March 3, 2003. Amendments apply to all preliminary determinations made under the policy on or after the effective date.

Subject	Policy or Item #	Comments
Miscellaneous	Various	Other amendments, effective March 3, 2003, include: • removal of references to former Part 3 administrative penalty process; • amendments to reflect new wording of section 99; • changes to disclosure provisions; • acknowledgement of WCAT authority to order the Board to pay expenses; • acknowledgement of WCAT authority to award costs; and • changes to reflect the payment of interest provisions under section 258. See resolutions 2002/12/17-02 and 2003/01/21-01 if more information is required. These amendments resulted from the *Amendment Act (No. 2), 2002* (Bill 63).
Calculation of Lump-sum Payment or Commutation	#45.61	Direction in policy on calculation of lump-sum payments or commutations after a review or appeal reinserted effective April 8, 2003, with appropriate changes to reflect new review/appeal structure. See resolution 2003/04/08-01 if more information is required.
Compensable Consequences of Work Injuries	#22.00	For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #22.00 of Volume II of this *Manual* regardless of the date of the original work injury or the further injury.
Further Injury or Increased Disablement Resulting from Treatment	#22.10	For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #22.10 of Volume II of this *Manual* regardless of the date of the original work injury or the further injury.

Subject	Policy or Item #	Comments
Disablement Caused by Surgery	#22.11	For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #22.11 of Volume II of this *Manual* regardless of the date of the original work injury or the further injury.
Travelling To and From Treatment	#22.15	For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #22.15 of Volume II of this *Manual* regardless of the date of the original work injury or the further injury.
Activities on Board Premises or at Other Premises under Board Sponsorship	#22.21	For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #22.21 of Volume II of this *Manual* regardless of the date of the original work injury or the further injury.
Injury Caused by Worker or Employer	#111.10	For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #111.10 of Volume II of this *Manual* regardless of the date of the original work injury or the further injury.
Schedule B Presumption	#26.21	For all decisions, including appellate decisions, made on or after June 1, 2004. See resolution 2004/05/18-02 if more information is required.
Herniae	#15.50	For all decisions, including appellate decisions, made on or after June 1, 2004, please refer to policy item #15.50, Herniae, in Volume II of the *Manual*. See resolution 2004/05/18-03 if more information is required.

Subject	Policy or Item #	Comments
Board Officers	#96.20	For all decisions, including appellate decisions, made on or after July 2, 2004, please refer to policy item #96.20, *Board Officers*, in Volume II of this *Manual*. See resolution 2004/06/22-03 if more information is required.
Disability Awards Officers and Adjudicators in Disability Awards	#96.30	For all decisions, including appellate decisions, made on or after July 2, 2004, please refer to policy item #96.30, *Board Officers in Disability Awards*, in Volume II of this *Manual*. See resolution 2004/06/22-03 if more information is required.

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

scope of the Act, and the Board is given express power to admit others at its discretion. Furthermore, the receipt of some sort of payment by such workers may lead to their being workers under the Act. Further information about volunteers can be found at 20:10:30 and 20:10:40 of the Assessment Policy Manual.

7.00 SPECIFIC INCLUSIONS IN DEFINITION OF WORKER

Section 1 includes within the Act's basic definition of "worker" certain classes of people who might otherwise not be covered. Those classes of people are discussed in detail in 20:10:30 of the Assessment Policy Manual.

7.10 Members of Fire Brigades

A volunteer member of a fire brigade is entitled to compensation for injuries arising out of and in the course of the activities of the fire brigade. This involves activities related to the process of firefighting even though not actually occurring while fighting a fire or during a drill or practice. It includes activities within the environs of the fire hall which are authorized and under the direction and control of the Fire Chief, such as activities involving maintenance to the building or equipment, snow clearance, etc. Coverage applies in the case of participation in practices, but not to travel to and from practices. However, there would be coverage in an actual emergency where the member is travelling to the firehall or the fire in response to the siren or returning home or to the member's regular job after the fire.

#8.00 ADMISSION OF WORKERS, EMPLOYERS, AND INDEPENDENT OPERATORS

The Act contains powers to admit workers, employers and independent operators.

A discussion of the situations where coverage may be extended under sections 2 and 3 of the Act is found at 20:10:40 and 20:50:00 of the Assessment Policy Manual.

#8.10 Federal Government Employees

The *Government Employees Compensation Act* grants "employees" of the Federal Government usually employed in the province the same rights to compensation as non-Federal employees. The definition of "employee" is given in Section 2 of this Act and takes the form of five alternative definitions which are as follows:

> "(a) any person in the service of Her Majesty who is paid a direct wage or salary by or on behalf of Her Majesty,

(b) any member, officer or employee of any department, company, corporation, commission, board or agency established to perform a function or duty on behalf of the Government of Canada who is declared by the Minister with the approval of the Governor in Council to be an employee for the purposes of this Act,

(c) any person who, for the purpose of obtaining employment in any department, company, corporation, commission, board or agency established to perform a function or duty on behalf of the Government of Canada, is taking a training course that is approved by the Minister for that person,

(d) any person employed by any department, company, corporation, commission, board or agency established to perform a function or duty on behalf of the Government of Canada, who is on leave of absence without pay and, for the purpose of increasing his skills used in the performance of his duties, is taking a training course that is approved by the Minister for that purpose, and

(e) any officer or employee of the Senate, the House of Commons or the Library of Parliament".

This definition is wide enough to cover most Federal employees, whether employed directly by the Government or by some statutory body. For example, it covers post office workers. The definition also includes certain persons taking training courses relating to their employment with the Government.

By Section 3(1) of the Act, members of the regular force of the Canadian Forces or of the Royal Canadian Mounted Police are excluded from coverage.

Any person appointed by authority of the Chief Electoral Officer and the *Canada Election Act* to prepare for and hold a Federal election is considered as an employee of the Federal Government for the purposes of the *Government Employees Compensation Act*. This definition includes Returning Officers, Election Clerks, Enumerators, Stenographers, Typists, Poll Clerks and a Constable.

Effective November 10, 1976, employees of the Bank of Canada are considered employees under the *Government Employees Compensation Act*.

CHAPTER 3

COMPENSATION FOR PERSONAL INJURY

#12.00 INTRODUCTION

The basic provision governing a worker's right to compensation for personal injury is Section 5(1). This provides that where, in an industry within the scope of the Act, personal injury or death arising out of and in the course of employment is caused to a worker, compensation as provided by the Act shall be paid by the Board.

The workers and employers covered were discussed in Chapter 2. This chapter considers primarily what constitutes a personal injury and when an injury or death arises out of and in the course of employment.

Apart from personal injury, the Board is authorized by Section 21(8) to replace or repair workers' artificial appliances, artificial members, eyeglasses, hearing aids, and dentures damaged at work. This section is discussed in #23.00.

#13.00 PERSONAL INJURY

“Personal injury” is defined as any physiological change arising from some cause, for example, a limitation in movement of the back or restriction in the use of a limb. It is not confined to injuries which are readily and objectively verifiable by their outward signs, e.g. breaks in the skin, swelling, discolouration, deformity, etc. It includes, for example, strains and sprains.

#13.10 Distinction Between an Injury and Disease

A common difficulty is to distinguish between an injury and a disease. This distinction is one that can be illustrated more easily than defined.

The following are examples of disorders classified as INJURIES:

1. Any wound (including any infection of the wound).

2. Fractures.

3. Any other disorder caused by trauma.

4. Any disorder caused by explosion (including hearing loss caused by explosion).

5. Sprains and strains, whether caused by a specific incident or by activity over time.

6. A damaged cartilage or ligament. It makes no difference whether the disability resulted from one major incident or a series of incidents or activity.

7. A dislocation of the bones at a joint. Again, it makes no difference whether this happened in one incident or in a series of incidents or activity.

8. Burns caused by a single incident of a chemical spilled on the skin.

The following are examples of disorders classified as DISEASES:

1. A disability caused by the gradual absorption of a chemical through the skin, by inhalation, or otherwise.

2. An infection (except when it is incidental to a compensable injury, when it is treated as part of the injury).

3. Hearing loss caused by exposure to noise over time, or by infection.

4. Osteoarthritis.

5. A disablement resulting from exposure to vibrations over time.

6. Contagious disease.

7. Allergic reactions.

Only diseases which are occupational diseases are compensable. The compensation payable in respect of occupational disease is discussed in Chapter 4.

In one case, a logger claimed in respect of damage to his knee that had been diagnosed as a fraying of the cartilage. He felt that his damage was the result of logging activity over a period of about five years, and did not allege that it resulted from a specific incident. It was concluded that, if it should appear that the fraying of the cartilage was externally caused through physical activity in which the claimant was engaged, and was not caused through degenerative disease, infection, or a disorder of internal origin, there was an injury rather than a disease.

In another case, the Adjudicator asked whether writer's cramp could be recognized as an occupational disease. It was concluded that claims for writer's cramp should be treated as claims for personal injury.

#13.12 Disablement from Vibrations

There are some situations in which a disablement from vibrations would be classified as an "injury". For example:

1. If the vibrations are of a traumatic nature, causing an instant disablement to a worker, such as an explosion.

2. If, though the vibrations may have occurred over a long period of time, the result was an instant or sudden disablement, possibly because of some sudden breakdown in the worker's system.

Apart from those cases, a gradual deterioration in a worker's condition resulting from exposure over time would not be an "injury", but would be classified as an occupational disease. For example, vibrating hand tools may cause the decalcification of small areas of the bones of the carpus, or damage to the soft tissues of the hand, or osteoarthritis in the elbows, wrists or shoulders, or vascular disturbances.

#13.20 Psychological Impairment

"Personal injury" includes psychological impairment as well as physical injury. A claim for traumatically induced psychological impairment could be accepted even if unaccompanied by any physical impairment. Psychological impairment has not been deemed to be an occupational disease. Conditions of this type however may be accepted if they are a sequela to an accepted personal injury or occupational disease.

#14.00 ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT

Before a worker becomes entitled to compensation for injury under the Act, the injury must arise out of and in the course of employment.

Confusion often occurs between the term "work" and the term "employment". Whereas the statutory requirement is that the injury arise out of and in the course of employment, it is often urged that a claim should be disallowed because the injury is not work related or did not occur in the course of productive activity. There are, however, activities within the employment relationship which would not normally be considered as work or in any way productive. For example, there is the worker's drawing of pay. An injury in the course of such

activity is compensable in the same way as an injury in the course of productive work.

Lack of control of a situation by the employer is not a reason for barring a claim otherwise acceptable. Control by an employer is an indicator that a situation is covered under the Act at a particular time, but if that control does not exist there may be other factors which demonstrate an employment connection.

No single criterion can be regarded as conclusive for deciding whether an injury should be classified as one arising out of and in the course of employment. Various indicators can be and are commonly used for guidance. These include:

(a) whether the injury occurred on the premises of the employer;

(b) whether it occurred in the process of doing something for the benefit of the employer;

(c) whether it occurred in the course of action taken in response to instructions from the employer;

(d) whether it occurred in the course of using equipment or materials supplied by the employer;

(e) whether it occurred in the course of receiving payment or other consideration from the employer;

(f) whether the risk to which the employee was exposed was the same as the risk to which the employee is exposed in the normal course of production;

(g) whether the injury occurred during a time period for which the employee was being paid;

(h) whether the injury was caused by some activity of the employer or of a fellow employee.

This list is by no means exhaustive. All of these factors can be considered in making a judgment, but no one of them can be used as an exclusive test.

#14.10 Presumption

Section 5(4) provides that "In cases where the injury is caused by accident, where the accident arose out of the employment, unless the contrary is shown, it must be presumed that it occurred in the course of the employment; and where

the accident occurred in the course of the employment, unless the contrary is shown, it must be presumed that it arose out of the employment."

Thus for injuries resulting from an accident, evidence is only needed in the first instance to show either that the injury arose out of the employment or that it arose in the course of employment. The balance is presumed, unless there is evidence to the contrary. Generally speaking, "out of the employment" concerns the cause of injury and "in the course of the employment" its time and place.

There are, however, some limitations on the use of this subsection.

First, it is not a conclusive presumption. It is rebutted if opposing evidence shows that the contrary conclusion is the more likely. All reasonable efforts must be made to obtain all available evidence.

Second, the presumption only operates when the injury results from an "accident". This term is defined in Section 1 to include a ". . . wilful and intentional act, not being the act of the worker . . .", and a ". . . fortuitous event occasioned by a physical or natural cause". This is not an exclusive definition of the term, but the word has been interpreted in its normal meaning of a traumatic incident. It has not, for example, been extended to cover injuries resulting from a routine work action or a series of such actions lasting over a period of time. The broad interpretation given to the term "accident" for the purpose of Section 4(1) of the *Government Employees Compensation Act* does not apply to Section 5(4) of the B.C. Act. (1)

#14.20 Occurrence or Non-Occurrence of a Specific Incident

Where an injury occurs at work as a result of any traumatic experience or external cause, it is usually from an accident to which the presumption in Section 5(4) applies. Thus, once it is established that the injury was caused by accident, and that the accident arose in the course of employment, the injury is presumed to have arisen out of the employment unless there is affirmative evidence that the injury was caused by factors external to the employment.

Consider the example of a worker who slips on the floor at work and is injured. Of course the worker could have slipped elsewhere and suffered a similar injury, but the worker didn't. The injury resulted from an accident in the course of employment. It is therefore presumed to have arisen out of the employment, and the injury is compensable, unless there is affirmative evidence that it was caused entirely by factors extrinsic to the employment.

Where there is no "accident", there is no presumption under Section 5(4) and the evidence must support a conclusion that the injury arose out of the

employment as well as a conclusion that it arose in the course of the employment.

It is not a bar to compensation when an injury occurs over a period of time rather than resulting from a specific incident. To be compensable, however, the evidence must warrant a conclusion that there was something in the employment that had causative significance in producing the injury. A speculative possibility that this might be so is not enough.

This does not mean that the presence or absence of a specific incident is never relevant in the decision of a claim for compensation. What it does mean is that the absence of a specific incident is not of itself ground for denying a claim. The existence of a specific incident may still be relevant in that:

1. There are some disabilities that are classified as resulting from an "injury" if they arise out of a specific incident, but are classified as resulting from a "disease" if they occur over time. (2)

2. The etiology of a disabling condition is always relevant, and the presence or absence of a specific incident may have some evidentiary value in establishing whether it was caused by any feature of the employment.

#15.00 NATURAL CAUSES

It is necessary to distinguish between injuries resulting from employment (which are compensable), and injuries resulting from purely natural causes (which are not compensable).

An injury is not compensable simply because it happened at work. It must be one arising out of and in the course of employment. If it happened at work, that usually indicates that it arose in the course of the employment. But it must also have arisen "out of" the employment. This means that there must have been something in the employment relationship or situation that had causative significance in producing the injury.

But if the injury was one arising out of purely natural phenomena – the internal workings of the human body – the employment situation may then be an irrelevant coincidence, and if so, the injury is not compensable.

#15.10 Worker Has Pre-existing Deteriorating Condition

There may be cases where an organ of the body is deteriorating, possibly through disease, and it has reached a critical point at which it is likely to become a manifest disability. Some immediate activity might trigger the final breakdown.

But if it had not been one thing it would most likely have been another, so that it is only chance or coincidence whether it happened at work, at home, or elsewhere. The disability is one that the claimant would not have escaped regardless of the work activity, and hence the causative significance of the work activity is so slight that the disability is treated as having resulted from the deteriorating condition. The disability is the result of natural causes and is not compensable. A Board decision illustrates the point:

> "An office worker goes to work at an office that is located above a store. He walks up one flight of stairs to his office and has a heart attack at the top. The evidence indicates a deteriorating condition of his heart. It indicates that a heart attack would not be unexpected and could be brought on by any activity at all. The disability is the result of natural causes and is not compensable."

On the other hand, there may be other cases where the deteriorating condition was such that, in the absence of some exceptional strain or other exceptional circumstance, it was not likely to reach a critical point and become a disability about the time of the work injury. The worker could well have survived without disability for months or years if something exceptional in the course of his employment had not triggered the disability. Here the employment situation had substantial causative significance and the disability is compensable. An illustration of the point comes from a Board decision which stated in part:

> "A transportation worker is moving a 300 lb. load up a flight of stairs when the load slips, causing fright and strain. The worker has a heart attack. Again the medical evidence indicates a deteriorating condition of the heart. But it supports a conclusion that the worker could well have survived for months or years without a heart attack had it not been for this unusually strenuous experience. Here the employment situation appears to have had causative significance and the heart attack is compensable."

It is sometimes said that an event at work "triggered" the disability. This does not, however, determine whether the disability is compensable. The circumstances, including the condition of the worker, must be investigated in such cases to determine which of the above applies.

#15.15 Firefighters and Heart Injury

The physical tasks involved in extinguishing fires and performing related rescue and hazardous materials responses expose firefighters to risks that are often unique to their profession. In this section the term "firefighter" refers to workers whose actual duties involve extinguishing fires and/or performing related rescue and hazardous materials duties. This section does not apply to workers employed in the firefighting profession who do not perform such duties. Evidence that a worker's job description includes the performance of such duties does not in itself render the worker a firefighter for the purposes of this section.

If during or within twenty-four hours immediately following attending a fire, rescue, or hazardous materials response the firefighter experiences:

- the onset of chest pain, collapse, cardiac arrest, or death due to myocardial infarction (heart attack); or
- the onset of symptoms, collapse, cardiac arrest, or death associated with an episode of acute cardiac arrhythmia;

a strong inference will arise that such condition was caused by the employment where during the course of attending such fire, rescue, or hazardous materials response the firefighter was exposed to:

- an intense physical effort sufficient to cause significantly increased heart rate and arterial blood pressure, or
- high temperatures and/or the wearing of personal protective equipment that significantly affected the firefighter's ability to thermo-regulate or that caused the firefighter to undergo intense physical effort, or
- environments containing asphyxiants such as carbon monoxide, carbon dioxide, or hydrogen cyanide, and that are likely to have produced oxygen deficiency in that firefighter.

The commencement of such twenty-four hour period begins when the firefighter leaves the scene of the fire, rescue, or hazardous materials response. Against this inference must be weighed any evidence which suggests that such cardiac condition is due to non-occupational factors. However, it is recognized that in rare cases the onset of symptoms associated with such cardiac condition may first occur between twenty-four and forty-eight hours following the above-described occupational exposure(s). Where the onset of such symptoms first occur more than twenty-four hours after the firefighter leaves the scene of the fire, rescue, or hazardous materials response, consideration is given to any evidence which may account for such delay in onset. In particular, consideration is given to all relevant clinical records, including hospital reports, that document the worker's condition.

Generally, the Board will determine that the firefighter's condition is not causally associated with the employment where the onset of symptoms, collapse, cardiac arrest, or death due to the above-described cardiac condition occurs:

- more than forty-eight hours following the time when the firefighter left the scene of such fire, rescue or hazardous materials response; or
- during or immediately following the performance of non-occupational activities that are likely to have caused the firefighter to experience significantly altered cardiovascular or respiratory function.

Against this inference must be weighed any evidence which supports the claim.

Where one of the above-described conditions is determined to be compensable, the Adjudicator must determine whether the worker was suffering from a pre-existing or underlying condition such as coronary artery disease. See #15.00, #15.10 and #30.70. Time loss and health care expenses that are solely attributable to treatment of the pre-existing or underlying condition through such interventions as angioplasty, coronary bypass and/or medications, are compensable only in circumstances where the pre-existing or underlying condition is compensable. Consideration will also be given to proportionate entitlement under Section 5(5) and to relief of costs under Section 39(1)(e) of the *Act* (also see #113.20 and #115.30).

See #7.10 regarding volunteer members of a fire brigade.

#15.20 Injuries Following Motions at Work

This heading refers to cases where an injury has followed a motion at work, but there was no deteriorating condition to bring the case within #15.10.

If a job requires a particular motion, and that motion results in injury, that is an indication that the injury arises out of the employment and is compensable. An example of this principle is a Board decision where the claimant's injury resulted from bending down and, for this worker, bending down was a required movement of the job. Another Board decision illustrates the point as follows:

> "An automobile mechanic working under a car is bending himself in unusual ways when he turns his head to look at something. Through some unusual movement of the neck muscles, he suffers a muscle strain. The employment activity may well have had causative significance and the injury is therefore compensable."

The same applies where a job requires a series of different motions, and an injury results from the series.

On the other hand, there may be situations where an injury resulted from some motion of the human body that was not required as part of the job. This would be an indication that the injury would not be compensable. Suppose, for example, that on walking along a road on an industrial site in the course of employment, a worker's head turns sideways as a matter of curiosity to see what someone is doing. Because of some peculiar movement in the neck muscles, a muscle strain occurs. That would not be an injury "arising out of" the employment, and therefore not compensable. Again, suppose a worker is using the toilet at work and, in doing so, suffers an injury resulting only from the bowel movement. That would not be compensable.

The injury may result not from any particular motion at any particular time and place, but rather from repetition of the same kind of motion over time, perhaps several weeks, perhaps several years. If the motion is one that the worker

undertakes in the course of employment, or predominantly in the course of employment, this would be an indication that the resulting injury would be compensable. But if the motion is of a kind that is undertaken at home and in the worker's social life as well as at work, this would be an indication that the resulting injury was not compensable. This point is illustrated in another Board decision:

> "If the injury is one that resulted from the natural condition of the worker together with the general activities of life, it would not be compensable simply because work was one of those activities. To be an injury arising out of the employment, there must be something in the employment that had a particular significance in producing the injury. For example, if a claimant has an injury to his knee and medical evidence indicates that this is caused by the use of stairs, it would not be compensable simply because the claimant uses stairs at work as well as at home and elsewhere."

It may often, in practice, be difficult to distinguish between work-required and non-work-required motions. Moreover, a work-required motion will often be a motion which the worker commonly engages in at home. This would suggest that the illustrations set out above are contradictory. However, the point is that it is not enough to consider only whether the motion is one which is undertaken at home, or only whether the motion was required by the worker's job. Illustrations are not intended to be substitutes for the exercise of judgment.

On the one hand, it is said that it should be sufficient to show only that the injury came on while the claimant was at work. The difficulty with this argument is that it renders meaningless the first half of the test contained in Section 5(1). If causation is to be measured solely by the fact of employment, why did the Legislature include a requirement that the injury must also "arise out of" the employment? Clearly something more is required.

On the other hand, it has been suggested the Board should disallow any claim for compensation where the motion which caused, or apparently caused, the injury is one which occurs constantly in the course of daily living. This argument would inevitably lead to absurd conclusions. Very little physical activity or body movement in a worker's employment differs significantly from that at home. The result is that virtually every body motion or activity could be said to be "normal" or "natural", capable of occurring off the job and therefore non-compensable. Clearly something less restrictive is required.

Claims of the kind under discussion here must be adjudicated with great care. Nevertheless, the necessity for the exercise of judgment will result occasionally in what may appear to be inconsistency or the application of slightly different criteria. This is inevitable in any situation where it is virtually impossible to draw a line. It is not advisable nor just to state that claims for injuries without accident can only be accepted where there was some demonstrable act on the part of the

claimant which was so directly connected with work that the relationship is indisputable. In particular, the present inability of medical science to accurately pin-point the etiology of a great variety of spinal problems, many of which have been shown to arise from the most trivial of incidents, leads to a conclusion that, in appropriate circumstances, such incidents should be seen as causative and if they occur while at work, the resulting injury must be compensable. On the other hand, the simple act of walking up stairs or turning one's head to speak to a co-worker or of looking down at one's hands while performing a certain job, fall so clearly into the realm of "natural" or "normal" bodily functions that the only connection between them and the employment is the coincidental fact that the worker was on the job at the time.

Simply by adding a few more facts to these situations or others it might well be possible, in individual cases, to find that a work relationship existed. For example, (and these examples are not to be taken out of context without consideration of the discussion above), if the worker were forced into an awkward position in order to properly perform the job and either while in that position or when arising from it suffered a sudden and severe onset of pain and discomfort, and the evidence shows no previous difficulty, it might well be that the only reasonable conclusion is that the apparently minor incident was causative. Similarly, if a worker bends to pick up an object, and that motion is required by the job (e.g. a piece of debris while on clean-up, a piece of mail while working in the mail room, an item of equipment or machinery in a plant) and, unrelated to the lifting of the object, suffers an onset of disabling pain, that apparently insignificant motion might also establish some work relationship. In either of these cases, the motion although natural was performed as a matter of the worker's duties and may in that sense gain "work" status.

#15.30 Recurring Temporary Disabilities

This refers to cases where a worker is subject to recurring disabilities of a temporary nature whether at work or elsewhere. A common example would be a worker who is subject to epileptic fits. Illustrations of the principles are:

1. A worker suffers an epileptic fit and is injured when hitting the floor. Both the fit and the injury result from natural causes and neither is compensable.

2. A worker suffers an epileptic fit, falls twelve feet from a scaffold, and suffers injuries on impact with the floor. Here the employment situation resulted in injuries beyond those that might have flowed from the natural causes, and though the fit itself is not a compensable injury, the injuries resulting from the fall from the scaffold are compensable.

The fit results from natural causes, and injuries resulting from the fit are not compensable. But if the employment situation results in injuries beyond those

that might have flowed from natural causes, the additional injuries resulting from the employment situation are compensable.

Where a claim is allowed for an injury substantially due to a personal illness of the worker such as epilepsy, the costs are excluded from the employer's experience rating (see #115.30).

#15.40 Ganglia

Ganglia are generally not considered to be of traumatic origin. As such, most claims for these conditions are not deemed to have resulted from a worker's employment and are not acceptable.

Exceptions may be made when:

1. a ganglion first appears between six weeks and six months following a deep penetrating wound or a contusion involving deep tissue damage at the site where the ganglion appears, or

2. a ganglion appears within six weeks of commencing work which is both unaccustomed and involves repetitive movements of joints or tendons at the site of the ganglion. This is considered an aggravation of the ganglion in a pre-disposed individual.

#15.50 Herniae

For all decisions, including appellate decisions, made on or after June 1, 2004, please refer to policy item #15.50, *Herniae*, in Volume II of the *Rehabilitation Services & Claims Manual.*

On the basis of the Board's present understanding of the biologic characteristics of herniae, the following principles are followed to determine the acceptability of hernia claims. It is, of course, essential that the claimed work causation circumstances should be reported to the employer as soon as is practicable.

1. Direct Inguinal Herniae

   (a) There must be increased intra-abdominal pressure or evidence of severe direct trauma resulting from the work or employment preceding the appearance of the hernia.

   (b) There should be no prior hernia at the site.

   (c) The age or general physical state of the claimant should be such as to predispose to the formation of a direct hernia.

(d) Pre-operative wage loss will not be allowed without adequate medical explanation of the reasons.

(e) Post-operative wage loss will be limited to 42 calendar days unless there are complications which justify an extension of the convalescent period and which are adequately described by the attending physician. The Board may require a further examination.

(f) The hernia will be considered to be an aggravation of a pre-existing condition and surgery will be recognized as an attempt to correct the aggravation.

2. Indirect Inguinal Herniae

(a) There must be increased intra-abdominal pressure resulting from the work or employment preceding the appearance of the hernia. The hernia should follow this event within a reasonable time period, normally no more than 72 hours.

(b) Where a claimant suffers bilateral herniae, it is extremely unlikely that both will have resulted from the same incident. However, where a claim for one of those hernia is acceptable in accordance with the principles set out above, the Board will accept responsibility for both herniae if the evidence is such that it is not possible to determine which of the two herniae did result from the employment.

(c) The hernia will be considered to be an aggravation of a pre-existing condition and surgery will be recognized as an attempt to correct the aggravation.

(d) Pre-operative wage loss will not be allowed except under unusual circumstances which are fully detailed by the attending physician.

(e) Post-operative wage loss will be limited to 42 calendar days except where there are complications which are fully explained by the attending physician. The Board may require a further examination.

In the case of inguinal herniae, sometimes the surgery must be done urgently because of certain threatening complications such as bowel obstruction or inability to reduce the hernia. Most often there is no urgency about the operation and seldom is there need to stop work while awaiting surgery. There is no medical evidence to suggest that work generally aggravates a hernia, makes the surgery more difficult or less successful, or increases the complications following surgery.

Where a treating physician's report certifies to the Board that the worker is disabled pre-operatively, other objective evidence regarding the worker's condition will be sought to either verify or dispute the treating physician's opinion. Usually this would consist of a medical examination at the Board.

When the first document is received on a hernia claim, a letter is immediately sent to the worker which states in part:

> "Please call (the Board) immediately if your doctor has told you to stay off work."

If the document indicates that the claimant is off work due to the hernia, the worker is also contacted by telephone by the Adjudicator to advise that the Board does not normally pay pre-operative wage loss on hernia claims. The adjudication of the claim is then accelerated. This could involve a telephone call to the employer to obtain the necessary information on which to base a decision.

Immediately following acceptance of the claim, if the claimant is still off work, the file will be discussed with a Board Medical Advisor, who should examine the claimant promptly if the question cannot be resolved by contacting the attending physician or surgical consultant. If the Board Medical Advisor confirms that the worker is not disabled, the worker is so advised at that time by the Adjudicator. This verbal decision is confirmed in writing. Wage-loss compensation will then only be paid up to the date of the examination, but will be reinstated as of the date of admission to hospital for surgery. The Board Medical Advisor may use discretion in such cases and decide to contact the treating physician to discuss the matter.

After surgery, the operative site usually heals without difficulty. Return to work in uncomplicated cases will be governed to some degree by the nature of the work to be done but is usually possible in four weeks. Some complications may delay this return to work.

3. Femoral Herniae

   These are unusual herniae and are generally not related to effort but may follow increased intra-abdominal pressure. Similar considerations will pertain as for inguinal herniae.

4. Epigastric Herniae

   These are not generally secondary to trauma or strain.

5. Incisional Herniae

   (a) If the primary incision is not the result of a compensable condition, the claim should be considered as a new claim and there should be:

      (i) an incident causing severe direct trauma to the site of the incision or marked increase in intra-abdominal pressure;

      (ii) the appearance of a hernia shortly after the occurrence of the trauma or incident;

      (iii) the incident or trauma should be reported to the employer as soon as is practicable.

   (b) If the primary incision is the result of a compensable condition, the claim should be considered as part of the original claim unless there has been a significant new trauma. If there has been significant new trauma, a new claim should be established.

6. Diaphragmatic and Hiatus Herniae

   These herniae should only be considered for compensation purposes if:

   (a) there has been a severe crushing injury to chest or abdomen; or

   (b) there has been direct trauma to the diaphragm (gunshot wound, stab wound, etc.) at the site of the hernia.

7. Internal Herniae

   These are not considered to be related to effort, strain or work and are not compensable.

8. Umbilical Herniae

   These are clearly congenital herniae and are not related to stress, strain, work effort or trauma, except in most unusual circumstances.

9. Incarceration of Herniae

   Incarceration of hernial contents may occur during effort in a claimant with a prior hernia. The Board responsibility in this case is limited to relief of the incarceration, usually possible by manual manipulation. If manual manipulation is unsuccessful, however, surgery may be necessary and if it is necessary for relief of incarceration, it is a Board responsibility.

EFFECTIVE DATE: June 1, 2004
APPLICATION: Applies to all decisions, including appellate decisions made on or after June 1, 2004.

#15.51 Prior Compensable and Non Compensable Herniae

1. Prior Compensable Herniae

   (a) Under 18 Months Since Claim Closed

   If no new incident is reported the Board may reopen the decision where a ground for reopening is met (see Chapter 14).

   If a significant new trauma is reported, it is usually adjudicated as a new claim.

   (b) Over 18 Months Since Claim Closed

   This is generally adjudicated as a new claim and is decided on the merits of the case. This consideration, however, also includes evaluating the question of reopening the old claim. The claim can only be reopened where a ground for reopening is met (see Chapter 14).

2. Prior Non-Compensable Herniae

   (a) Under 18 Months Since Prior Herniae

   These are adjudicated on the merits of the case. Because of the potential for recent hernia repairs to break down, it is expected that to be acceptable there must be clear evidence to establish a relationship of the breakdown to the worker's employment.

   (b) Over 18 Months Since Prior Herniae

   These are adjudicated on the merits of the case.

EFFECTIVE DATE: March 3, 2003 (as to references to reopening)
APPLICATION: Not applicable.

#15.60 Shoulder Dislocations

Where a worker has previously had a primary shoulder dislocation and suffers a further, or recurrent dislocation at work, if the original or primary dislocation was not sustained as a compensable injury, its acceptance as a new claim would depend upon whether there was a work incident of sufficient causative significance to induce a further dislocation. If there is a prompt reduction of the recurrent dislocation, there may be no disablement from work and consequently no need for wage-loss benefits. Where there is a disablement, this should not normally endure more than two weeks. Surgery, if directed at the pre-existing primary cause of the recurrent dislocation, would not normally be considered as an entitlement. An exception to this principle could arise where there was a non-compensable dislocation many years previously and evidence shows that the shoulder had been stable for many years without any recurrent dislocation or where the recurrent dislocation at work was induced by **severe** trauma. In such a case, entitlement might not be limited to the same extent and could include surgical repair.

Where the primary dislocation was compensable, should surgery be undertaken, it would normally be handled under the original claim unless the condition has been stable for many years with no intervening difficulty or the recurrent dislocation at work was induced by **severe** trauma. In such circumstances the surgery may be dealt with under the new claim.

#16.00 UNAUTHORIZED ACTIVITIES

The mere fact that a worker's action which leads to an injury was in breach of a regulation or order of the employer or for some other reason unauthorized by the employer does not mean that the injury did not arise out of and in the course of the employment. On the other hand, there will be situations where the unauthorized nature of the worker's conduct is sufficient to take the worker out of the course of employment or to prevent an injury from arising out of the employment.

#16.10 Intoxication or Other Substance Impairment

Since it is seldom possible to have blood alcohol level or other test data available in adjudicating such claims, other evidence is used to evaluate the existence and extent of any impairment.

Claims involving impairment should be classified under the following headings.

1. Workers Permitted to Drink

   There may be cases where drinking was part of the permitted activities of the employment. For example, bartenders or other kinds of sales representatives may have been encouraged or permitted by their employers to drink with customers. In that kind of case, any injury resulting from intoxication would generally be compensable. But there may well be exceptions, for example, where it is concluded that the worker had gone beyond the pursuit of the employer's interests to engage in a purely social event.

2. Workers Not Permitted to Drink

   Where drinking is not a permitted part of the employment, injuries resulting from intoxication or other substance impairment must be adjudicated as follows:

   (a) Employment causation

   If the injury arose in the course of the employment, and something in the employment relationship had causative significance in producing the injury, it is still one arising out of and in the course of employment notwithstanding the impairment. Examples are where an intoxicated sailor fell into the water while attempting to board a vessel, and where a forest industry worker was run over by a logging truck. In these kind of cases, if the injury results in death or serious or permanent disablement, it is compensable.

   Once it is apparent that an injury is one arising out of and in the course of employment, it does not cease to be so merely because some other factor, extrinsic to the employment, also has causative significance. An industrial injury is often caused, for example, by inattentiveness due to nausea, depression, lack of sleep, or a variety of other factors. But it is still compensable.

   (b) No employment causation

   There may be cases where, although the injury occurred at work, impairment alone was the cause. Suppose, for example, a worker is walking over normal ground when, unable to maintain support as a result of impairment, stumbles to the ground and is

injured in the fall. In that case, it might appear that nothing in the employment relationship had any causative significance in producing the injury. It would then not be an injury arising out of the employment and not compensable. Also, as indicated in #16.60, a worker's actions or conduct may induce the Board to conclude that the injury did not arise out of and in the course of the employment.

#16.20 Horseplay

A worker who is injured through participation in horseplay is not for that reason alone denied compensation. The conduct of the claimant which caused the injury must be examined to determine whether it constituted a substantial deviation from the course of the employment. An insubstantial deviation does not prevent an injury from being held to have arisen in the course of employment.

No definite rules can be laid down as to what constitutes a substantial deviation. One factor to be considered is the degree of participation of the claimant. For instance, a claimant who instigates or provokes horseplay, or who has been involved in previous episodes of horseplay, will more likely be considered to have made a substantial deviation than one who simply reacts to actions commenced or provoked by someone else.

The duration and seriousness of a claimant's horseplay is also of relevance in considering whether there has been a substantial deviation from the course of employment. For example, if a worker walks over to a co-employee to engage in a friendly word, and accompanies this with a playful jab in the ribs, this is a trivial incident which would probably be considered an insubstantial deviation. As Larson notes,

> "At the other extreme, there are cases in which the prankster undertakes a practical joke which necessitate the complete abandonment of the employment and the concentration of all his energies for a substantial part of his working time on the horseplay enterprise." (3)

When this abandonment is sufficiently complete and extensive, it must be considered a substantial deviation from the course of employment. It is also relevant to consider whether the "horseplay" involved the dropping of active duties calling for the claimant's attention as distinguished from the mere killing of time while the claimant had nothing to do. The duration and seriousness of a deviation from the course of employment which will be called substantial will be somewhat smaller when the deviation necessitates the dropping of active duties than when it does not.

#16.30 Assaults

In considering cases of assault, the first question is whether the claimant was the aggressor and therefore the agent which caused the injuries. The answer to this question is not always clear cut and may involve an evaluation of the degree to which a claimant is an aggressor in a given situation. However, the fact that a claimant is less than friendly with another employee and is at least equally responsible for ill feeling that may prevail between them is not, by itself, grounds for disallowing a claim for injury arising out of an assault by that other employee.

The second question is whether there is a connection between the employment and the subject matter of the dispute which led to the assault or whether it was a purely personal matter. In the latter case, the claim is not acceptable.

Where an assault arises out of the worker's employment, no compensation is payable unless it also arises in the course of the employment.

The same principles apply if the assault is by someone other than a fellow employee.

#16.40 Injury While Doing Another Persons Job

Some latitude must be given to workers to act upon their own initiative. It is clearly impossible for an employer to lay down fixed rules covering every detail of a worker's employment activity. Therefore, workers may be uncertain as to the limits of their work. A worker should not be prejudiced if the worker is careless or exercises bad judgment in an area where it is reasonable to exercise some discretion. Thus an act which is done bona fide for the purpose of the employer's business may form part of a worker's employment, even if not specifically authorized by the employer. For example, it has long been the policy of the Board to accept claims from workers injured as the result of some emergency action to protect their employer's property or to rescue their fellow workers. Suppose also that a worker, who has ceased to work at a particular machine, goes to the aid of a successor who is having trouble operating the machine. One would expect that the employer would not want the worker to refuse to assist the new employee on the technicality that it was not within the scope of the worker's employment.

On the other hand, there is a clear need to place some limit on the activities which form part of a worker's employment. Thus, for example, if an act is specifically prohibited by an employer or is known, or should reasonably have been known, to the worker to be unauthorized, or, if the worker has been previously warned against doing other persons' jobs, the worker would not usually be covered merely because of a bona fide action for the benefit of the

employer. On the other hand, it might be different if, for example, the employer had previously condoned a prohibited practice carried out by employees or some emergency forced a worker to act.

If a worker performs some work activity without the employer's instructions, this is an indicator that any resulting injury did not arise out of and in the course of the employment. On the other hand, this factor does not exclusively determine the compensability of the injury. It must be weighed along with the other factors set out in #14.00 and any other relevant factors. If it is outweighed by other indicators that the injury arose out of and in the course of the employment, the injury will be compensable under the Act.

#16.50 Emergency Actions

Where an emergency occurs at a time when a worker is in the course of employment, the worker is considered to be covered if injured when acting to protect a fellow worker or protect the employer's property. If, however, the action is that of a public spirited citizen, she or he would be doing no more than anyone would do, whether or not working for an employer at the time. This cannot be considered to be related to the employment.

However, there is an exception to this general proposition, notably where the injury occurs through the presence of a hazard on the premises of the employer.

The situation can perhaps best be illustrated by an example. Suppose a worker receives a telephone call at work indicating that there is a fire in a portion of the employer's premises. The worker races from the office and, due only to haste, trips over his or her own feet, falls and injures an arm. There is no doubt that in light of the relationship of the emergency to the employment this injury would be compensable. In other words, it would be found to have arisen out of the employment.

Suppose, then, that the same worker receives a telephone call to the effect that a family member has been seriously injured in an accident. Once again the worker races from the office and, due only to haste, falls and injures an arm. In these circumstances there is no relationship to the employment. The reason for the worker's departure is totally unrelated to the employment and nothing about the employment contributed to the injury. However, if the worker were to race from the office and trip over a poorly laid carpet, a relationship to the employment would be present. In other words, the injury would not have occurred had it not been for a hazardous condition on the employment premises.

Therefore, while it is incorrect to say that compensation will be payable when a worker is injured while leaving the premises of the employer for whatever reason, it is correct to say that any injury will be compensable which was suffered in any emergency and which also arose out of a hazard on the employment premises.

Even if the injury does not arise from a hazard of the employment premises, and the emergency does not concern a fellow worker or the employer's property, claims may still be accepted from workers who, in the ordinary course of their work, are situated in an environment which by its very nature may become the site of an emergency situation. An excellent example of this "positional risk" would be all employees in the various aspects of the operation of an airport. The Board is of the understanding that, for example, at Vancouver International Airport groups or "teams" are formed to act in cases of emergency. The members of these groups will be drawn from various aspects of the operation and the nature of their specific employment may be totally unrelated to emergency rescue. Baggage handlers or concession operators could not be considered to have as part of their employment the need to react in the event of a crash of an aircraft. Nevertheless, their very presence as employees at the airport places them in the position of being the logical choices to become members of such teams. Apart from this exception, the fact that the employment places one in a position to observe an emergency cannot be of itself a determinative factor in granting compensation.

If a worker's injury is the result of an emergency action to prevent a crime, there may be entitlement to benefits under the *Criminal Injury Compensation Act*. (4)

#16.60 Serious and Wilful Misconduct

Section 5(3) provides that "Where the injury is attributable solely to the serious and wilful misconduct of the worker, compensation is not payable unless the injury results in death or serious or permanent disablement."

By the terms of Section 5(3), the injury must be attributable "solely" to the worker's misconduct. Thus, for example, where the worker was impaired by reason of alcohol or other substances, investigation will have to be carried out to evaluate the extent of the impairment and its degree of responsibility in producing the injury in order to establish whether this requirement is met. See #16.10 for further details.

The section only applies where the misconduct was serious and "wilful". In determining whether misconduct is wilful it must be considered whether the claimant had pre-knowledge or voluntarily elected to break a rule. In other words, the claimant must be aware of a rule and knowingly elect to break it.

The section does not bar a claim if the injury results in death or serious or permanent disablement. The word “serious” is used in a physical rather than an economic sense. Therefore, if for example a worker has suffered a sprained wrist or finger which causes only two or three weeks loss of wages, this may not be considered as a serious disablement even though the loss of earnings may cause a serious financial problem. However, if a disability is prolonged, it may be regarded as serious even though the initial injury appears minor.

Where a claim involving serious and wilful misconduct is accepted, the cost of compensation paid after the first 13 weeks of disability is excluded from the employer’s experience rating (see #115.30).

Before Section 5(3) can be considered, it must have been determined under Section 5(1) that the injury arose out of and in the course of the employment. The actions or conduct of the worker may induce the Board to conclude that the injury does not meet that requirement. If such a conclusion is reached, the claim will be denied even though the worker has suffered death or serious or permanent disablement.

#17.00 HAZARDS ARISING FROM NATURE

An injury may result from natural elements. For instance, a worker may be stung by an insect or plant or suffer from exposure to extreme weather conditions. Compensation in these cases is limited to situations where the job is of such a nature as to place the worker in a greater position of hazard to these elements as compared with the public at large.

Some examples of the application of this rule are set out below.

#17.10 Insect Bites

A logger stung while working in the bush would have a claim accepted, as would a letter carrier who is stung while walking through a flower garden in summer to deliver a letter. Claims have also been accepted from people bitten by tropical insects while unpacking bananas.

On the other hand, an office worker stung by a bee in the course of office work would not generally qualify.

#17.20 Plant Stings

An employee of a florist shop is an obvious example of a person who could successfully claim for a plant sting.

#17.30 Frostbite, Sunburn and Heat Exhaustion

If a worker is working outdoors in below freezing temperatures and sustains frostbite, a claim will qualify for acceptance as resulting from a work related hazard. The same would apply to a worker working for a prolonged period in a walk-in freezer.

Persons suffering abnormal exposure to the sun because of their employment are also covered.

The failure of a worker to wear protective clothing may in some cases be ground for denying a claim under Section 5(3).

#17A.10 Commencement of Employment Relationship

The commencement of compensation coverage is not marked by common law principles relating to the commencement of a contract of service. A decision must be made whether, having regard to the substance of the matter, an employment relationship had begun for compensation purposes.

For example, where the place of employment is some distance from the available labour market, workers may arrive at the place of employment in a number of ways. If workers go there of their own initiative looking for whatever jobs they may find, they take the risk of travel upon themselves. But if an employer extends its network of hiring arrangements to distant places, and induces a worker to leave a distant city and journey to the employer's place of work upon the promise of travel time and expenses, the journey becomes part of the employment relationship, and the hazards of the journey become risks of the employment.

A person offering services to an employer will often be told to come back at a certain time in the future when work might be available. A person may also be promised a specific job but the commencement date may be specified some weeks or months ahead. Such persons would not normally commence to be workers under the *Workers Compensation Act* until they actually returned to the employer's premises at the future date and commenced work.

It is not essential that a person must actually have commenced productive work for an employer before being covered. If, for example, an injury took place while entering the employer's premises on the way to the first day of work the worker may be covered. The employment relationship would have commenced at the moment of entry to the premises and would not have been delayed until completion of the necessary hiring formalities or actual commencement of work. Coverage might even commence earlier in the journey to work that morning if the situation falls within one of the other exceptional cases when travelling to work is regarded as part of the employment.

#17A.20 Termination of Employment Relationship

The same principles apply to the termination of employment as to the commencement of employment. An employment relationship does not automatically terminate for compensation purposes when a contract of service is terminated by notice. Workers are covered for a reasonable period while winding up their affairs and leaving the employer's premises.

#18.00 TRAVELLING TO AND FROM WORK

The general position is that accidents occurring in the course of travel from the worker's home to the normal place of employment are not compensable. But where a worker is employed to travel, accidents occurring in the course of travel are covered. This is so whether the travel is a normal part of the job or is exceptional.

#18.01 Entry to Employers Premises

Compensation coverage generally begins when the worker enters the employer's premises for the commencement of a shift, and terminates on the worker leaving the premises following the end of the shift. Thus where a worker is travelling to work by automobile, there is no coverage for compensation from home to the point of entry to the employer's premises, but there is coverage from there to the worker's particular place of work. However, a Board decision denied a claim from a worker who, having entered her employer's premises and decided not to cross a picket line, was injured before she had left those premises as the result of tripping over a cement abutment.

It is a responsibility of the employer to provide a safe means of access to and egress from the place of work. Thus where a worker is travelling by highway to a place of work that is not adjacent to the highway, and must cross other land before reaching the employer's premises, compensation coverage begins at the point of departure from the highway rather than the point of entry to the employer's premises.

It is not considered significant that a worker is injured while seeking to gain access to the employer's premises by a method that is probably different from that which the employer intends. In a Board decision, it was irrelevant that the deceased fisher attempted to jump aboard his employer's boat rather than use a ladder that was available. However, the outcome might be different if the method used has been specifically forbidden by the employer and the worker is aware of this.

The worker in that decision was attempting to board the ship to sleep there in preparation for sailing the following day. It was not significant whether he was required to board the ship the night before, or whether he had an option about the time of boarding. He was in any event attempting to board the ship for the purpose of work the following day.

#18.10 Road Leading to Employers Premises

The general rule is that there is no coverage while a worker is travelling along the roads which lie between the worker's place of residence and the employer's premises. However, in some cases, the nature of the road leading to the employer's premises may give coverage while on that road.

#18.11 Captive Road Doctrine

A "captive road" is one which is technically a public highway but as a practical matter leads only to the premises of the particular employer and is for practical purposes under the control of that employer. In such a case, the road might be classified as part of the employer's premises for compensation purposes. The case would be particularly strong if it was found that the employer made decisions on repairs. In a Board decision, the application of this doctrine was rejected because the road in question was used by at least three employers.

In another Board decision, a miner was killed in an automobile accident while driving home along the road leading from the mine where he worked. The mine was located in a park, 27 miles from the main road. The road also gave access to a public camp ground, 17 miles from the main road, and another work place of the same employer, 23 miles from the main road. There was no other highway access to the mine, and it was normal for workers of the employer to travel by automobile along the road. The claim was allowed on the grounds that the road was a "captive road" at the point where the accident occurred, 24 miles from the main road. The question whether the "captive road" terminated at the access to the public camp ground or the main road was left open.

It appeared that the title to the road vested in the Crown, and that it was probably a public highway right to the mine site. Both the Department of Highways and the employer participated in the original construction of the road. Since that time, however, the Department of Highways had not participated in the operation of the road. The Department of Highways had not placed its usual hazard signs on the road, nor had it participated in maintenance. Through its relations with the Crown, the employer appeared to be under a legal obligation to maintain the road from the mine to the boundary of the park (seven miles from the main road), but in practice, it maintained the road all the way to the main road.

There was evidence that the public did use the road right up to the mine, but this use was by occasional tourists going nowhere in particular or by people looking for fishing spots. This limited use by the public was not inconsistent with the "Captive Road Doctrine".

In another case, the claimant was injured in a motor vehicle accident while travelling from home along a private road owned, controlled and maintained by the employer. The argument that it was a "captive road" was rejected because the road also led to the plants of several other employers and a public recreation area which were located further along the road than the plant of the claimant's employer. The use of the road by the public up to and beyond the employer's plant was significant. The further argument, that the claim should be accepted because the road formed part of the employer's premises, was also rejected. While it was agreed that, generally speaking, injuries occurring on the employer's premises were compensable, it was not accepted that the extent of the employer's premises for this purpose could simply be determined by whether the employer legally owns or controls the property in question. To take an obvious example, there would be no coverage if an employee were injured at the employer's home when invited there out of work hours on a purely social occasion. It is apparent, therefore, that regard must be had to other factors such as the use to which the land is normally put and its relationship to the operation of the employer's business.

The "Captive Road Doctrine" lays down situations when a road, though technically a public one, can, in effect, be regarded as part of the employer's premises for compensation purposes with the result that coverage extends to injuries occurring on it. This occurs when the road for practical purposes leads only to the employer's premises and can, therefore, be equated with a private road which is just an incidental feature to the employer's plant. The natural corollary of this doctrine is that, where a road is technically a private one, it should not be considered as part of the employer's premises where in reality it leads to the premises of several different employers and is indistinguishable from a public highway. The road is not then just an incidental feature of the plant of the one employer who happens to own the road. It appeared that roads leading to an employer's premises should be classified for compensation purposes by the real nature of their use and hazard. The Board should not be artificially distinguishing roads otherwise indistinguishable on the basis of legal ownership and control. It was concluded that the road concerned in this claim must in reality be considered as a public highway rather than a private road forming an adjunct to the employer's premises.

The Board's policy with regard to "captive roads" has never been that an injury occurring on such a road is compensable regardless of the circumstances of the injury. Just as an injury is not compensable just because it happens on the

employer's premises, an injury is not compensable just because it occurs on a "captive road". The circumstances surrounding the injury may indicate that, notwithstanding the place where it occurred, it did not arise out of and in the course of the employment. Therefore, a claim for an injury on a "captive road" was denied when the accident was due to the dangerous condition of the claimant's own vehicle.

An injury on a "captive road" does not arise out of and in the course of the employment if the journey along that road is not for a legitimate purpose associated with the employment.

#18.12 Special Hazards of Access Route

Where a place of work is so located that for access and egress the worker must pass through special hazards beyond the ordinary risks of highway travel, an injury sustained from those hazards is one arising out of and in the course of employment. On the other hand, an injury to a worker on the way home from work, even though on the only egress route from the employer's premises, is not compensable if it results from other normal risks of highway travel, such as a collision between two automobiles.

In a Board decision, a dead-end street led to the employment premises of the claimant and other employers. The claimant was injured by a train while driving over a railway crossing situated close to the employer's premises on this road on her way home from work. Since this crossing differed from other crossings in the city and was of a type lacking typical safety features, it was a special hazard, and a claim in respect of the injury was allowed.

In another decision, it was argued that the accident resulted from a special hazard of the industrial environment, and therefore a hazard of egress from the employer's premises. In this connection, reference was made to the bends in the road being sharper in the mountains than was normal for lowland highways, to falling rock on the road, to crosswinds, and to ice patches in winter. While the evidence with regard to the existence of these conditions was accepted, they were seen as hazards of mountain highways rather than a special hazard of egress from this kind of work place. The claim was, therefore, not allowed under the special hazard doctrine. In another case, the argument was made that there were special hazards on the road to the employer's premises arising from poor road conditions due to snow. This was rejected because these conditions were no more than was to be ordinarily expected on any road during winter in the interior of the province.

For a claim to succeed on the grounds of a special hazard, the hazard need not lie on the only route to the employer's premises. It is sufficient if it is on the normal route to the place of work from the direction in which the claimant is travelling.

If a worker is injured in the immediate approaches to the place of work, though still on the highway, that will be compensable if the hazard causing the injury is a spill-over from the employer's premises. For example, if an accident occurs through rush hour congestion right at the gates of the plant, that would be compensable, and the Board would certainly not measure by an exact line whether it occurred inside or just outside the gates.

#18.20 Provision of Transportation by Employer

An employer may directly or indirectly provide transportation for its employees' journeys to and from work. In situations where this involves providing a specific vehicle such as, for example, a crew bus, in which the journeys are made, compensation coverage is generally extended to injuries occurring while travelling in this employer-owned vehicle. In some situations, the employer may let the worker choose her or his own mode of transportation, but pay for all or part of the costs of this transportation. The employer may also pay the worker a wage for the time spent in travelling. While these factors must be considered, the basic question to be determined is whether or not the claimant is routinely commuting to or from work. The fact that coverage does not extend to include routine commuting could override the fact that the worker is being paid a travel allowance or a wage to cover the commuting. This is distinct from the crew bus situation described above which can be deemed to be an extension of the employer's premises.

#18.21 Provision of Vehicle by Employer

In a Board decision, the claimant was injured while travelling to work on a bus run by a company pursuant to a contract between the company and the employer. The employer argued that the rule outlined above did not apply because the bus service was not provided directly by the employer, but through an independent contractor. The bus company had complete control over the service which was used by other members of the public than the employer's workers. Employees paid a fare for riding the bus and had a choice as to whether to use this means of riding to work. In effect, the service was being equated with any other regular bus service run for the purpose of public transportation.

The argument that this rule did not apply was not accepted. Leaving aside the fact that control by the employer is not a necessary factor before compensation coverage exists, it was considered that the employer did in that case exercise a significant degree of control over the bus service. It was, to begin with, a party to the contract which set out the terms and conditions on which the service operated. The contract also allowed the employer to direct the amount of the fare paid by its employees and to enact rules or regulations which applied to the

operation of the buses. The contract could be terminated by the employer on 90 days' notice. The bus service was not at all like a regular bus service open to the public. It was, in practice, used virtually exclusively by workers of the employer and another authorized company and its use by other members of the public was by comparison minimal and unofficial. The fares paid by the employees were nowhere near to covering the cost of the service which was met by the employer and appeared to be token in nature.

Though the bus service was not specifically provided for in the collective agreement, it was a matter which had been the subject of a separate agreement between the union and the employer. The reasons for a reduction in fares resulting from this agreement were not known, but clearly could have had nothing to do with the economics of providing the service. This agreement pointed to the fact that the bus service was not an independent body and separate service which the employer had induced another company to operate but, rather, a service provided by the employer through the agency of another company, which was subject to its overall direction and control. There was no justification for distinguishing this type of case from one where the company directly provide the service itself using its own employees.

The same rule was also applied where, because of working overtime, the claimant missed the regular bus service home provided by his employer. He was injured while travelling home in a taxi arranged and paid for by his employer and his claim for compensation was accepted. It made no difference that the collective agreement did not require the employer to provide the taxi.

This rule does not apply when the employer provides the worker with a vehicle for the purpose of work and allows personal use outside of work hours. An injury occurring while travelling in that vehicle to and from work will not be compensable just because the employer provided the vehicle. Nor would such an injury be compensable where the vehicle is the claimant's own just because it is taken to work in order to be used in the course of employment.

#18.22 Payment of Travel Time and/or Expenses by Employer

The payment of wages or travelling allowances etc. may in some circumstances be a factor to be considered, but it usually will not be a significant factor, nor is it ever the sole criteria in determining the acceptability of a claim.

Where the place of employment is some distance from the available labour market, workers may arrive at the place of employment in a number of ways. If workers go there of their own initiative looking for whatever jobs may be found, they take the risk of travel upon themselves. But if an employer extends the network of hiring arrangements to distant places, and induces a worker to leave a distant city and journey to the employer's place of work upon the promise of

travel time and expenses, the journey becomes part of the employment relationship, and the hazards of the journey become risks of the employment.

In the Lower Mainland area, stevedores are normally required to report to the hiring hall in Vancouver in the morning. They are then dispatched to the various employers in the area. When dispatched outside the City of Vancouver itself, for example North Vancouver, stevedores have the option of transportation in their own vehicle or to use a taxicab at the employer's expense. No similar allowance is made within the city limits of Vancouver. In view of this exceptional circumstance, stevedores are covered under compensation from the point when they leave the city limits in which the hiring hall is located while travelling to a work place outside the city limits, whether they use a taxicab provided by the employer or use their own vehicle. No coverage applies when travelling to destinations within the city where the hiring hall is located.

The remoteness of a work site and the limited availability of transportation are factors which may suggest that a journey from the work site may be part of the employment. There is a difference between a journey between two established towns and cities with regular and established means of communication and a journey between one such town and a remote place consisting only of a work site. The fact that a flight is a scheduled one does not fundamentally alter the more hazardous nature of the latter type of journey, though a scheduled flight system may possibly provide greater safety than an unscheduled one.

#18.30 Journey to Work Also Has Employment Purpose

There may be situations where the journey is not simply a routine matter of driving to and from work, but there are also some additional circumstances which connect the journey with some particular aspect of the claimant's employment. This additional circumstance may be sufficient to bring all or part of the journey within the scope of the employment.

#18.31 Worker On Call

Workers are not covered while routinely travelling to and from work simply because as part of their contract of employment, they are liable to be called out from their homes at any time to deal with a matter connected with their employment. They are, however, covered if because of an emergency or some other reason they have to make a special journey from their homes to their employer's premises or to some other place where the job has to be done.

#18.32 Irregular Starting Points

There are a number of different situations that have to be considered under this heading. One is where the worker is injured in the course of a journey between home and a normal or regular operating base. That situation is substantially similar to the case of a worker travelling between home and a fixed place of employment and an injury occurring in the course of that journey would not be covered.

Another situation is where there is an injury occurring in the course of a journey between what might be called two working points. That is, where the worker terminates productive activity at one point and then has to travel to commence productive activity at another point. If that occurs in the course of a working day, then the travel is one of the requirements of the job. It is one of the functions that the worker has to perform as part of the employment whether or not the worker is paid for it. Where the worker terminates productive activity at one point and is required to commence productive activity at another point, travel between those points is part of the employment and is in the course of employment as long as the worker is travelling reasonably directly and is not making major deviations for personal reasons.

A different situation arises when the job function requires the worker, after first reporting to the employer's premises or assembly area, to travel to a work location. Clearly, the worker's travel from home to the employer's premises or assembly area would be considered commuting and, as such, would not warrant compensation coverage. The worker's travel from the employer's premises or assembly area to the point where he or she will begin work is normally covered as being in the course of employment. This situation is distinct from that of union members who go from a hiring hall to different work locations and, perhaps, to different employers each day. (See #18.22, third paragraph, "Stevedores".)

A further situation arises when the job function requires the worker to report at what might be called irregular starting points. That is, different starting points on different days or different months and terminating employment at different termination points. This could apply, for example, to bus drivers. In cases where such a driver must first report to the depot to receive an assignment, travel from home to the depot would not be covered under compensation. The question as to whether the driver's travel from the depot to the point where the run will begin should be covered as being in the course of employment is distinct from that of union members who go from a hiring hall to different work locations and, perhaps, to different employers each day. There is only one employer in this case and the worker is sent from the employer's premises. In such a situation, once the worker has been dispatched from the depot to journey to the point where the run will begin, as long as the worker is proceeding toward that place with reasonable expedition and without substantial deviation, the worker

should be considered to be travelling in the course of employment and hence covered for compensation regardless of whether public or private transportation is used. The question has also been raised as to whether the driver would be covered for compensation in travelling from the finishing point to the depot at the finish of a shift. Where a driver has completed work and is returning to the depot and is travelling reasonably directly and does not make any major deviations for personal reasons, the driver would be considered in the course of employment until such time as the depot is reached.

Where a worker has a regular or usual place of employment and is assigned temporarily to work at a place other than the regular place of employment, the worker is covered for compensation while travelling to and from that temporary place, and this is so whether the worker goes there from the regular place of employment or goes there directly from home. The same rule applies, for example, to a delivery person who goes direct from home to make deliveries.

#18.33 Deviations From Route

Where an employee is instructed by the employer to perform some activity related to work while on the way to or from the normal place of work, this does not necessarily provide coverage for the whole journey. Generally speaking, it will only provide coverage to the extent that the employee has, because of these instructions, to do something which would not normally be done while travelling to or from work or go somewhere where the employee would not normally go. This is particularly so when the instructions only require a minor diversion from what is essentially a normal journey to work.

In one case, an employee was asked to stop on his way to work and have snow tires put on his employer's car that he was driving. His claim was denied because he was injured close to his home and at the beginning of a normal journey to his office. He still had a fair distance to travel before he would divert from this route to work to carry out his employer's instructions. The place where the snow tires were to be fitted was close to his office and the fact that he had to go there did not appear to have significantly affected the initial part of his journey. Though road conditions were bad and thus provided some risk, this risk was one that he would, in any event, have to meet in travelling to work. He had to leave earlier to enable him to carry out his employer's instructions, but this reduced rather than increased the risks of the journey.

Where a worker is covered while travelling to a place of work, that worker must proceed with reasonable expedition and without substantial deviation from the most convenient route. Otherwise the worker may be regarded as no longer in the course of employment.

#18.40 Travelling Employees

Employees whose job involves travelling on a particular occasion or generally are covered while travelling. Where they do not travel to their employer's premises before beginning the travelling required by their work, they are covered from the moment they leave their residence. However, they will not be covered if they first travel to their employer's premises even though their vehicle has been provided by their employer and/or they need that vehicle to do the travelling required by their work.

#18.41 Personal Activities During Business Trips

The basic principle followed by the Board is set out in Larson's *Workmen's Compensation Law* as follows:

> "Employees whose work entails travel away from the employer's premises are held . . . to be within the course of their employment continuously during the trip, except when a distinct departure on a personal errand is shown." (5)

This principle covers the activities of travelling, eating in restaurants, and staying in hotels overnight where these are required by a person's employment.

What is meant by the reference to a "distinct departure on a personal errand"? It clearly does not simply refer to such everyday activities as eating, sleeping or washing which, in the case of most non-travelling employees would be regarded as personal activities outside the scope of the employment when performed outside normal work hours. Such activities will normally be regarded as within the scope of the employment of an employee who is required to travel. On the other hand, if, for example, a person on a business trip attends a theatre or spends the evening in a public house, these would probably not be regarded as activities in the course of employment.

The test to be applied is set out in #21.00.

Normal activities such as eating, sleeping and washing can be regarded as personal activities which are incidental to the stay in the hotel required as a result of the employment. Where a worker goes out for a purely social evening, the worker may be staying in a hotel as a result of employment, but this employment feature of the situation may be clearly outweighed by the personal nature of the social activity.

In a Board decision, the deceased worker was an independent truck operator. Having delivered his loads earlier in the day, he went to a hotel for a social evening, drinking beer with friends from 7:00 p.m. until approximately 1:00 a.m.

At that time, he left the hotel. While driving the truck from there to the place where he usually parked it for the night, he was unfortunately killed. If the deceased had simply stopped for a short refreshment break after completing his deliveries and before returning home with his truck, the Board might well have concluded that he was still in the course of employment. But here the deceased had long since finished his employment functions of the day. The social evening was not a brief and incidental diversion. This was not a small feature of private life featuring in a sequence of employment activity. Rather, this was a case where an incident of the employment (i.e. the truck) featured incidentally in the social activity and private life of the deceased. The death was, therefore, not one arising out of and in the course of employment.

An injury may arise in the course of an employment activity but will not be compensable unless it also arises out of the employment. In the case of a worker who has to stay in a hotel on a business trip, this means that the injury must be caused by some hazard of the environment into which the worker has been put by the employment. In particular, this includes hazards of the hotel premises itself. Thus, for example, an injury will be compensable if it arises from the collapse of all or part of the hotel building or the burning down of that building. Another example would be where a claimant is required to stay in a hotel as part of the employment. Although engaged in a personal activity; leaving the bathroom, at the time of the injury, it is regarded as merely incidental to the requirement that the claimant stay overnight in the hotel. The injury resulted from tripping over a sill, a fairly obvious hazard of the hotel premises. The injury, therefore, is considered to have arisen both in the course of and out of the claimant's employment. It follows that injuries resulting from some hazard introduced to the premises by the claimant for personal benefit will not be considered to have arisen out of the employment.

In another decision, a sales supervisor sustained a back injury while lifting a spare tire into the trunk of his car on Saturday, while preparing for a business trip to commence on Monday. If the claimant had been lifting display materials into the trunk of his car or had been involved in cleanup or repairs in which he would not normally have been involved, then there may be little doubt that an injury received under such circumstances would be compensable. The claimant's evidence at the board of review hearing, however, indicated that employees were responsible for all maintenance on their cars. The question then is whether the standard of upkeep was any more than that which a person would normally do. In this case, it appears that the repairs effected and the subsequent cleanup were normal duties carried out by car owners. There is little on the facts to suggest that these actions were connected with the employment relationship as opposed to being undertaken in the claimant's capacity as a car owner. The claim was therefore disallowed.

#18.42 Trips Having Business and Non-Business Purpose

Whatever other requirements there may be for accepting a claim for an injury occurring on a trip made for business and non-business purposes, one essential is that the injury occur at a time when the claimant is or is substantially on the route which leads to the place where the business purpose is to be carried out. No compensation is payable where the injury occurs while the claimant is making a significant deviation from that route for non-business purposes.

#19.00 USE OF FACILITIES PROVIDED BY THE EMPLOYER

Where a worker is injured in the course of using some facility supplied or provision made by the employer, the use of such facility or provision may be part of the employment relationship; and injuries resulting therefrom may be injuries arising out of and in the course of employment.

This rule is considered in relation to the situations set out below.

#19.10 Bunkhouses

The use of residential premises by a worker is considered as part of the employment where the worker is required to use those premises by the employer, where there is no reasonable alternative accommodation, or their use is encouraged or contemplated by the employer. However, where an employer is simply providing accommodation for the employer's workers as an additional service, and the availability of suitable alternative accommodation gives the worker a reasonable choice between that provided by the employer and that provided by others, the worker's use of the employer's accommodation is not within the scope of the employment.

Where a camp is isolated or for other reasons the worker has no reasonable choice about staying in accommodation provided by the employer, injuries resulting from the use of facilities provided by the employer on the camp site will normally be held to have arisen out of and in the course of the employment. This applies not only to residential but to recreational facilities. This principle is illustrated by the facts of a Board decision where a claim was allowed from a man working for a mining company in a remote area of British Columbia and living in a bunkhouse provided by the company at a townsite approximately half a mile from the mine. Some time after the end of his shift the claimant was going for a recreational walk, and was injured in a fall while descending the steps of the bunkhouse.

On the other hand, another claim where the claimant was injured when he slipped on the ice while leaving his apartment in the town of Kitsault was denied. The townsite was owned and created by a mining company to accommodate its

employees, but a little less than half the population were employees. The town provided a variety of residential, social and recreational facilities. The apartment in question was owned by the company and rented to the claimant at a rent slightly below market value. It was argued that the whole townsite was one large bunkhouse, but this was rejected. While the town was remote, this was not in itself sufficient. The rules extending coverage to bunkhouses did not apply to the situation where a company initiated and owned operation had evolved into a self-contained, viable community differing in its social structure from a normal town or village only by virtue of the fact that the principle employer is the sole property owner. There was no isolation from a normal personal and social life suffered by workers living in the town.

In another decision, the worker resided in a bunkhouse on a camp complex of his employer located close to Kelsey Bay. There were recreational facilities and living accommodation available to the worker in Kelsey Bay and most of his fellow workers took advantage of them. The claimant was injured when he fell down the steps of a building on his employer's camp complex which was being used for holding a film show. The claim was denied and distinguished from the first example on the basis of the remoteness of the work site in that decision.

Even where the bunkhouse is not isolated and there is other available accommodation, there may be coverage where the bunkhouse accommodation is provided free of charge and the worker would have to pay for other accommodation. In practice, most persons would stay in the bunkhouse in such a situation and only those who had existing homes nearby would likely exercise the option to live elsewhere. The freedom of choice would be more theoretical than real and this may be a factor which indicates that coverage should extend to residing in the bunkhouse. On the other hand, while in the case of an isolated camp, coverage may extend to injuries arising from both residential and recreational facilities, the same will not necessarily be the case when the bunkhouse is located close to the town and alternative facilities. Economic factors may make a worker's freedom to choose the worker's own residence largely theoretical, but this does not extend to the choice of recreation. In the Kelsey Bay case described above, the claim was for an injury occurring in the course of a recreational activity.

An injury occurring on the premises of the employer will not be compensable if it results from the introduction to the premises of a hazard by the worker, for example, where the worker accidentally shoots himself or herself with the worker's own shotgun. (6)

#19.20 Parking Lots

For the purpose of determining whether an injury occurring in a parking lot is compensable, the Board looks at five basic questions.

First, was the lot provided by the employer for the worker? The unauthorized use of a parking space by a worker would normally exclude the acceptance of a claim on the basis that the injury was not work related. There will, however, be exceptions where the employer, while not authorizing the parking, has condoned the practice by default in failing to take action to prohibit the practice.

Second, was the lot controlled by the employer? (The fact that a lot is owned or leased by an employer does not, in itself, automatically imply that it is controlled by the employer.) Claims are received for injuries occurring in parking lots not owned by the employer, but as a result of some arrangement, the worker is permitted to park there. If the lot is controlled by the employer, a claim may be acceptable. In claims involving shopping centre or shopping mall parking lots which are designed primarily for customer use and not controlled by the individual employer of a claimant, an injury occurring on such premises would not normally be considered as acceptable.

Third, was the injury caused by a hazard of the premises? This is intended to limit acceptance to only those injuries which have a connotation of "employment relationship". For example, a slip on a pool of oil or a trip over an obstruction would qualify. On the other hand, claimants who nip their fingers in their own car doors would not have their claims accepted. (7) There will also be claims which are not a direct result of the premises which may qualify, such as a pedestrian struck by a fellow employee's car. The term "hazard of the premises" is not an absolute requirement for compensation coverage. Rather it illustrates the distinction between injuries resulting from personal causes and those resulting from the employment. In effect, the type of injury that would qualify for acceptance if it occurred on a factory floor would also qualify for acceptance if it occurred in a parking lot.

Fourth, was the parking lot contiguous to the place of employment? The word "contiguous" is defined as meaning both adjacent to and attached to. While desirable, it should not be deemed a mandatory prerequisite for acceptance. Non-contiguous lots, particularly those under the direction, supervision or control of an employer do qualify although coverage does not normally extend to workers while they are making their way to them across and along public thoroughfares.

Finally, did the injury occur proximal to the start or stop of the shift? If there is a significant time gap between the time of an accident and the start or stop of the shift, the matter is investigated to determine whether there is an employment relationship.

#19.30 Lunchrooms

Claims for injuries occurring in lunchrooms are acceptable if the lunchroom is provided by the employer. Again coverage is limited to reasonable use of the premises and would not extend to injuries sustained through eating food, unless this had been provided by the employer, and the employees had been specifically required to eat food provided by the employer, or it was provided as part of the worker remuneration.

People who have to travel in the course of their employment are covered during normal meal breaks. But a non-travelling employee who chooses to have a coffee break in a coffee shop across the street from the employment, rather than use the company facilities, would not be covered. (8)

#19.31 Injury Results from Claimant's Personal Property

An injury which arises in the course of the employment will not be compensable if it arises out of exposure to a hazard or risk which is not related to the worker's employment. If a worker is injured through exposure to a hazard which the worker, as a personal matter, introduced into the workplace, that injury is not considered to have arisen out of the worker's employment. This principle was applied in a Board decision where the claimant fell backwards off a bench on which he was sitting eating his lunch. As a result of the fall, a paring knife which he had brought from home for the purpose of eating his lunch, stuck into his thigh. The claim was denied because the claimant had introduced an exceptional hazard onto the premises of the employer for his own personal use. The injury suffered would have been very minor or non-existent if the paring knife brought to work by the claimant had not been lying on his lap at the time of the injury.

It is not essential that the personal property that causes the injury be intrinsically hazardous. It is sufficient that it causes the injury in the particular case. In general, injuries are not compensable where they result entirely from personal property brought onto the employer's premises by claimants for their own purposes and have no connection with their employment.

#19.40 Medical Facilities

The provision of medical or first aid facilities by an employer may be a factor indicating that an injury resulting from their use arose out of and in the course of employment.

#19.41 *Adverse Reactions to Inoculations or Injections*

The following principles apply in claims arising from an adverse reaction to injections or inoculations:

1. Where the injection or inoculation is received voluntarily by the worker, either as part of a broad program put on by the employer or in any other circumstances, a claim should not be accepted.

2. Where the inoculation or injection is required, either as a condition of employment or as a condition of continued employment (such as where the claimant has suffered an injury or contracted a disease outside the work environment, but the employer insists on precautionary measures being taken before the worker returns to employment), the claim should be allowed.

3. Although each claim has to be decided on its merits, generally a subjective test should be applied to determine whether or not the worker was "compelled" to take the treatment. For example, in one claim submitted for consideration, the following factors were taken into account:

   (a) the employer had established a program whereby tetanus shots were given when metal cuts occurred;

   (b) although the first shot was with consent, the notice for the booster shot left the impression that it was required. In other words, no choice was specifically given. The worker was merely advised he was to attend at a specific time and place to receive the shot;

   (c) since no worker had ever refused a booster shot, there was further group or peer pressure and it was unlikely that a worker would feel free to refuse;

   (d) that unlikeliness was increased by the claimant's language difficulties.

   In general then, if the evidence is clear that the claimant was personally convinced that it was necessary to take the shot in spite of objective evidence from the employer that the process was not compulsory, the claim should be accepted.

#20.00 EXTRA-EMPLOYMENT ACTIVITIES

Generally speaking, activities which people undertake outside of their employment are for their own benefit and injuries occurring in the course of them are not compensable. There are, however, some activities which because of their relevance to the claimant's employment may be accepted as being part of that employment.

#20.10 Participation in Competitions

Subject to the general rules relating to compensation coverage, an injury sustained by a worker while participating in a first aid competition, mine rescue competition, or fire-fighting competition, or while travelling to or from such an event, will be considered one arising out of and in the course of employment if the following conditions are satisfied.

1. The type of skill or knowledge that the competition is designed to test or promote must be a type of skill or knowledge of service to the worker in her or his employment. For example, if it is a first aid competition, the worker must be one who functions as a first aid attendant in her or his employment, or be a trainee for such a function. It is not necessary, however, that the worker should function in this capacity regularly or on a full-time basis. It is sufficient if the worker functions in the capacity on a standby basis while having another regular job function.

2. The worker must be a participant in the event, not merely a spectator. The worker will be considered a participant if either:

   (a) the worker is a participating or reserve member of a competing team, or;

   (b) the worker is a coach or trainer, or;

   (c) the worker is appointed or assigned to assist in the organization or administration of the event, or;

   (d) the worker has job responsibilities relating to first aid, mine rescue, or fire-fighting similar to those of the competitors, or is training for such responsibilities, and is attending to improve her or his skill or knowledge relating to those responsibilities.

3. The participation of the worker in the event must be sponsored or requested in some way by his or her employer. If the employer has not specifically requested the worker to attend, a request may be implied from the circumstances. For example, a request for the worker to attend may be implied if:

(a) the worker is paid for the whole or any part of the period of her or his participation, or;

(b) the worker is paid for the whole or any part of the time spent in training for the event, or;

(c) the employer makes some contribution towards the expenses of the worker for attending the event, or;

(d) the employer provides supplies or equipment for the worker's participation or her or his training for the event.

#20.20 Recreational, Exercise or Sports Activities

The organization of, or participation in, recreational, exercise or sports activities or physical exercises is not normally considered to be part of a worker's employment under the *Workers Compensation Act*. There are, however, exceptional cases when such activities may be covered. The obvious one is where the main job for which a worker is hired is to organize and participate in recreational activities, for instance, a physical education teacher in a school. There may also be cases where, although the organization or participation in such activities is not the main function of the job, the circumstances are such that a particular activity can be said to be part of a worker's employment.

It is not possible to define exclusively what these circumstances are. The following factors are, however, considered:

1. Activities Part of Job

   Were the activities part of the job? A physical education teacher involved in team sports with the pupils would normally be covered whereas participation in a sport with fellow-teachers, particularly outside of working hours, would not likely warrant coverage. A ski instructor enjoying personal skiing activities or, of his or her own volition, takes part in a ski race or competition would not be covered. If, however, the competition or race involved the instructor's pupils and was deemed part of the teaching activities, then coverage would likely apply.

2. Nature of Direction

   Was participation directed, requested or voluntary?

(a) Directed

Was the worker instructed or otherwise directed by the employer to carry out the exercise activity or to participate in the sports activity? The more positive the form of direction, the more likely it is that coverage will apply. Adjudicators, however, have to measure whether or not what may have been termed a direction was in reality no more than a request.

(b) Requested

Did the employer request, suggest, or simply sanction participation? In such situations this is less likely to favour coverage, though the overall adjudication will still depend upon the combined relevancy of other related factors.

(c) Voluntary

Was participation purely voluntary on the part of the worker? Where this is the case, it is generally not sufficient to extend coverage to the worker's activities. This applies equally to recreation, exercise or sports activities.

3. During Working Hours

Did the recreational, exercise or sports activity occur during normal working hours? Where this is the case, it usually favours coverage, but does not necessarily guarantee it.

4. Outside Working Hours

(a) Recreational or Exercise Activities

In the case of recreational or exercise activities, coverage outside of working hours is not extended. This limitation applies to paid lunch breaks even if the worker could be considered on call at that time. As a limitation, it also involves situations where, in keeping with the physical fitness demands of a job, the employer requires the performance of exercise activities at home. An employer cannot extend the coverage of the Act by simply labelling an off-duty exercise requirement as mandatory.

(b) Sports Activities

Sports activities outside of normal working hours are similarly not covered. The Board has, in the past, developed exceptions in the case of claims involving police officers. Where appropriate, these can be applied to other like situations. The guidelines are:

(i) The employer has directed participation in the activity.

(ii) The sports activity involved the public, or a section of the public with which the worker deals, and was clearly designed to foster good community relations.

(iii) Full salary or wages was paid while participating.

(iv) If a team sport, the team was financially supported by the employer.

(v) The team was composed entirely of fellow employees.

(vi) There was no involvement with a commercial team or recreational league.

5. Paid Salary

Was the worker paid full salary while participating in the activity? The payment of salary favours coverage, but is not an absolute guarantee. If full salary is not being paid, coverage is unlikely, or at least questionable, depending upon other related circumstances.

6. Activity Supervised

Was the activity supervised by a representative of the employer having supervisory authority? This strongly favours coverage. The fact that the activity was not supervised does not favour coverage. In situations involving recreational or exercise activities off the employer's premises, coverage does not apply if it is not supervised.

7. Fitness a Job Requirement

Was physical fitness a requirement of the job? While this is always evaluated in conjunction with other factors, if it applies, it is a favourable factor toward extending coverage. The requirement for physical fitness in a job does not, however, in itself guarantee coverage for such activities. A distinction must be drawn between things a worker must do to become and continue to be qualified to perform a particular job, and the things a worker must do as part of the job. Generally speaking, only the latter activities are covered. In the

case of recreational or exercise activities, if physical fitness is not a job requirement, then coverage is not extended. It is recognized that any recreation or exercise activity which adds to a worker's general health and enjoyment of life may be said to assist them in their work and, therefore, to benefit their employer. However, to cover these activities under the *Workers Compensation Act* for that reason alone would obviously be to expand its horizons far beyond what the Legislature intended.

8. Public Relations

In the case of organized or team sports activities, was there an intention to foster good relations with the public, or a section of the public with which the worker deals? If this applies, then depending on other related factors, coverage may be extended. If this public relations factor is not applicable, coverage is unlikely to be extended. Coverage will never be extended if the sports activity involves a contest with a commercial team or recreational league.

9. On Employer's Premises

Did the activity take place on the employer's premises? This is a positive factor favouring coverage but it must be evaluated in conjunction with other relevant factors. If the activity took place off the employer's premises, and was a sports activity, the guidelines listed previously in the items dealing with working hours apply. Recreational or exercise activities occurring off the employer's premises are only covered where:

(a) The employer funds or subsidizes the activities.

(b) The funding or subsidization was in the form of fees paid to a commercial exercise facility such as a gymnasium or health and exercise spa.

(c) The activities were part of a formal exercise or training program instituted by the employer.

(d) The actual activity was directly supervised by a representative of the employer having supervisory authority.

(e) The activity occurred during normal shift hours for which salary was being paid. (This includes paid lunch breaks.)

(f) The activity was required, encouraged or at least sanctioned by the employer.

(g) The nature of the job function is such that a high level of physical fitness is desirable.

#20.30 Educational or Training Courses

A distinction must be drawn between things workers must do to become and continue to be qualified to perform a particular job and the things they must do as part of the job. Generally speaking, only the latter activities are covered. A person may, for example, need to spend some time in an educational or training institute to obtain or maintain the qualifications necessary for a particular job, but that person is not normally covered while attending that institution.

Compensation coverage does not extend to injuries occurring in the course of first aid courses being taken off the employer's premises and outside work hours. This is so, even though the worker receives additional pay for a first aid ticket and is reimbursed the course fees by the employer.

Injuries in the course of training programs undertaken under the auspices of the Board following a compensable injury are dealt with in #88.54.

#20.40 Provision of Clothing and Equipment Required for Job

The fact that a worker is required to provide tools for the job does not mean that carrying the tools to work or away from work becomes part of the employment. A worker may have to satisfy many prerequisites before obtaining a job, for example, education, experience, physical condition, clothing, equipment, or travelling to the work site. After the completion of a job, a worker may have to carry out various activities of a consequential nature, for example, cleaning clothes, removing equipment or travelling from the work site. None of these activities are normally covered as part of a worker's employment under the *Workers Compensation Act*. Nor does the mere fact that the employer pays certain expenses associated with these activities result in coverage.

In one case, a claimant was injured while lifting his tools from out of his car at the end of his journey from work. He had received travel time and expenses for that journey. The claim was denied. The fact that the claimant was covered while travelling because of the receipt of travel time and expenses did not mean that he was also covered while removing tools at the end of the journey. The wages were paid for travelling, not for carrying tools. Coverage on the basis of the travelling allowance ended when he parked the car outside his home.

Changing clothes prior to starting or after finishing work is not normally part of the employment, whether it takes place at home, on the employer's premises or elsewhere.

#20.41 Injuries Resulting from Workers Clothing or Footwear

Injuries resulting from the wearing of clothing or footwear are adjudicated according to the following principles:

1. The clothing in question must be necessary for the job.

2. As in all other cases, the injury must arise out of and in the course of employment. Therefore, if there is nothing in the employment activity which would reasonably cause an injury and that injury can be seen to be directly related to the ill-fitting nature of the clothes, the claim should be disallowed. However, even though the clothing may be ill-fitting, if the job involves certain activity which might in the ordinary course of events and with proper clothing cause the injury, the claim should be allowed.

3. Who purchased the clothing or item in question is irrelevant.

#20.50 Fund Raising, Charitable or Other Similar Activities

Situations occasionally arise when a person is injured while participating in fund raising, charitable or other similar activities; for example, a charity collection activity off the employer's premises, either during or outside of working hours. Other examples could involve school teachers participating in a bake sale, a car wash, a walkathon, etc. with a view to raising funds for field trips, or other similar peripheral activities not covered by direct school funding.

Two of the statutory tests set in Section 5(1) of the *Workers Compensation Act* for the adjudication of personal injury claims are the requirements that the injury be arising out of, and in the course of, the employment. Much has been written about these two tests, part of which is that the interpretation of the word "employment" should not be restricted to actual productive activity. The nature of any non-productive activity, however, has to be evaluated in order to determine whether it meets, or extends beyond, the legislative intent of these two tests. The guidelines listed in #14.00 are, while not exhaustive, useful in making such determinations. Fund raising, charitable or other similar activities do not meet the requirements of these two statutory tests. To extend the interpretation of the Act to include such activities would be to expand the horizons of the Act beyond what the Legislature intended.

Claims received for injuries occurring in the course of fund raising, charitable or similar activities will not, therefore, be deemed acceptable. This, however, does not apply to persons who are employees of charitable or other like agencies which are covered under the Act, or to persons from other companies who are seconded for a period of time to work with such agencies.

#21.00 PERSONAL ACTS

There is a dilemma that is always inherent in workers' compensation. The difficulty, of course, is that the activities of workers are not neatly divisible into two clear categories, their employment functions and their personal lives. There is a broad area of intersection and overlap between work and personal affairs, and somewhere in that broad area the perimeter of workers' compensation must be mapped. An incidental intrusion of personal activity into the process of work will not require a claim, otherwise valid, to be denied. For example, it has long been accepted that compensation is not limited to injuries occurring in course of production. Where persons are injured while at work in the broader sense of that term, claims will not be denied on the ground that at the precise moment of injury they were blowing their noses, using the toilets or having their coffee break. Similarly it has long been accepted that when a truck driver stops for a meal in the course of a long journey and is injured while crossing the road the driver is just as much entitled to compensation as a factory worker injured on the way to the works canteen. Conversely, the intrusion of some aspect of work into the personal life of an employee at the moment an injury is suffered will not entitle the employee to compensation. For example, if someone slips in the living room at home and is injured, that person is not entitled to compensation simply on the ground that at the crucial moment the person was reading a book related to work. In the marginal cases, it is impossible to do better than weigh the employment features of the situation in balance with the personal features and reach a conclusion (which can never be devoid of intuitive judgment) about which should be treated as predominant.

Where the common practice of an employer or an industry permits some latitude to employees to attend to matters of personal comfort or convenience in the course of employment, compensation for injuries occurring at those moments is not denied simply on the ground that the employee is not at the crucial moment in the course of production. This is within the scope of the established doctrine relating to acts which, though not in themselves productive, are nevertheless a normal incident of employment.

#21.10 Lunch, Coffee and Other Breaks

A worker is considered to be acting in the course of employment not only when doing the work the worker is employed to do but also while engaged in other

incidental activities. For example, a worker does not cease to be in the course of employment while having a lunch or coffee break on the employer's premises, while going to the toilet, having a smoke or other such activities. Therefore, if while engaged in such activities the worker is injured by virtue of some aspect of the work environment, a claim will be accepted. On the other hand, not all injuries occurring while engaged in such activities will be compensable. The injury must "arise out of" the employment as well as "in the course of" it. Thus, for example, if a worker has a heart attack while having a smoke during working hours a claim will likely be denied. This is because the heart attack probably arose from natural causes and was not caused by any aspect of the employment rather than because, in having a smoke, the worker was no longer in the course of employment.

In one case the claimant, during a paid coffee break, went out from her place of work to her employer's parking lot with the intention of moving her car closer to the mill entrance. However, before she could do this, she trapped her finger in the car door while shutting it. The purpose of moving the car was to allow her to leave work more quickly and easily at the end of the day. She did not cease to be in the course of her employment when she walked out to the parking lot. It was not unreasonable for her to go out to her car during her coffee break. The evidence established that there was a common practice for employees to do this which was acquiesced in by the employer. If, for example, she had tripped over a pot hole in the lot, any resulting injury would have been compensable. It would have arisen out of the employment, as well as in the course of the employment, as it was caused by a hazard of the employer's premises. It was considered that, in trapping her finger in her car door, she had not suffered an injury which arose out of her employment. The car was her personal property which she had brought onto the employer's premises for her own convenience. It was a hazard arising from the use of this property which caused her injury.

This case should be contrasted with another claim where the claimant during a break in production, ran out to his car in the parking lot to get a package of cigarettes and twisted his ankle. His claim was denied. A person is considered to be in the course of his employment while entering and leaving his employer's premises at the start and end of his shift and at other recognized coffee or lunch breaks. This may also extend to other times when a worker has to leave his employer's premises for good reason, for example, in emergencies. However, not all trips to and from the worker's place of work can be treated in this way. There will be trips for personal reasons unrelated to the work and which cannot be said to be simply incidental to that work. There is no coverage in such cases. The trip made in this case was of that kind.

It was considered that more was involved here than such activities as blowing a nose, smoking a cigarette, or going to the toilet, which would normally be accepted as incidental to the employment. The rationale for accepting such

activities is that they benefit the employer by making his employees comfortable while they are working and, therefore, in the long run, more efficient. It can, of course, be argued that the claimant's going to get his cigarettes benefited his employer by putting him in a position where he would be able to smoke and make himself comfortable. However, it seemed that this doctrine should be limited to the specific activities which make the worker more comfortable and not to other secondary activities which put him in the position of doing these activities.

#21.20 Vacations

Generally speaking a person who works during a vacation from normal employment is acting in a personal capacity and unless personal optional protection has been purchased from the Board, or the claimant is working in another employment covered by the Act, there will be no coverage for workers' compensation purposes. In some few cases, there may be evidence showing that, although the employee is on vacation, the employee is in fact working for the usual employer. However, this cannot be simply assumed because the employee is doing work of a type normally done and for someone who is also a customer of the employer.

In a Board decision, the claimant repaired a recreational vehicle which was owned by him and a partner and such repairs took place while the claimant was on holidays. The claimant and his partner, operating under the firm name of "X", also leased the vehicle to the general public on occasion, and had a contractual arrangement for maintenance of, and repairs to, the vehicle with "Y", a firm of which the claimant and his wife were principals. The claimant contended that the repairs were performed in his business and not his personal capacity, but the claim was denied. Apart from the claimant's own testimony, there were no objective facts to indicate that he was acting in the course of his employment at the time of injury. The mere fact that the claimant was the principal of "Y" and that "Y" subsequently submitted an invoice for the work to "X" was insufficient.

#21.30 Payment of Wages or Salary

Where a worker is injured in the course of receiving the consideration for the employment, the acceptance of such consideration is part of the employment relationship, and injuries resulting therefrom are injuries arising out of and in the course of employment.

This clearly covers a worker injured while drawing wages in cash at the pay office of an industrial plant. However, it may also apply where an employee is paid by cheque and is injured in the course of converting that cheque into a usable form, either by cashing it or by depositing it in the employee's own bank

account. If the cashing or depositing of the cheque occurs in circumstances which, in some other respect, have a significant employment connection, compensation will normally be paid.

In a Board decision, a truck driver was driving his employer's truck back to the yard at the end of his shift when he decided to call in at the bank on his way and cash his pay cheque. While crossing the road to return to his truck after cashing the cheque the claimant was hit by a passing vehicle. It was decided that in so far as the claimant may have undertaken a diversion to attend to a matter of personal concern, this was so trivial compared with the continuing employment features of the situation that it would be wrong to treat the personal aspect as controlling.

#21.40 Acts for Personal Benefit of Principals of Business

In the case of independent operators with personal optional protection and active principals of small companies, it is necessary to distinguish between the activities of the claimant carried on in furtherance of the business for which he or she or the company is covered by the Act and independent, personal or business activities which are not so covered. Only injuries occurring while pursuing the former type of activity are covered by the Act. For example, in one claim, the principal of a small plumbing and heating company was injured while fogging mosquitoes on property belonging to himself and to other members of a property owners association. Although the claimant's company supplied the materials used, there was no evidence that the fogging was done as part of the business of that company. Rather, the evidence indicated that it was an independent personal enterprise carried on by the claimant on behalf of himself and the association. The facts of the case set out in #21.20 also illustrate the same principle.

On the other hand, in another Board decision, the claimant was employed by an auto body shop, a limited company of which Mr. "X" was President and part owner. After making a delivery to a customer with Mr. "X", the claimant was requested to assist Mr. "X" to pick up a bed and deliver it to his mother. The claimant injured his back while moving the bed. This took place within normal working hours. The claim was disallowed by the Adjudicator because moving the bed was not related to the employer's business as a body shop owner. This argument had merit vis-a-vis the fact that the claimant's legal employer was a limited company. However, the board of review felt that for practical purposes Mr. "X" was the employer. Moving the bed was for the benefit of Mr. "X", and at the same time Mr. "X" asked the claimant to assist him in moving the bed, he was being paid by him and was acting under his directions.

#22.00 COMPENSABLE CONSEQUENCES OF WORK INJURIES

Once it is established that an injury arose out of and in the course of employment, the question arises as to what consequences of that injury are compensable. The minimum requirement before one event can be considered as the consequence of another is that it would not have happened but for the other.

Not all consequences of work injuries are compensable. A claim will not be reopened merely because a later injury would not have occurred but for the original injury. Looking at the matter broadly and from a "common sense" point of view, it should be considered whether the previous injury was a significant cause of the later injury.

EFFECTIVE DATE: For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #22.00 of Volume II of this *Manual* regardless of the date of the original work injury or the further injury.

#22.10 Further Injury or Increased Disablement Resulting from Treatment

Where a further injury arises as a direct consequence of treatment for a compensable injury, the further injury is also compensable.

Where a worker is undergoing treatment for a compensable injury, the place of treatment is analogous to a place of employment, and a further injury arising out of the place of treatment would also be compensable. For example, if a worker is undergoing treatment at a hospital for a compensable injury and sustains a further injury by stumbling down the stairs in the hospital, that is also compensable.

EFFECTIVE DATE: For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #22.10 of Volume II of this *Manual* regardless of the date of the original work injury or the further injury.

#*22.11 Disablement Caused by Surgery*

Compensation is not limited to the direct consequences of work accidents. Ordinarily, when a claimant undertakes surgery for the injuries sustained, the consequences of the surgery are accepted as consequences of the accident, and any disablement resulting from the surgery is treated as compensable. No doubt an exception could be made if a claimant recklessly undertook surgery, knowing that it was likely to do more harm than good. In that case, a claimant might be viewed as having introduced a new cause of disablement. There may be other grounds for making an exception, but there is no rational ground on which an

exception can be made simply because the surgery was not authorized by the Board.

In a Board decision, the claimant had suffered a compensable injury at work, but had then become disabled following surgery carried out without the Board's authorization. The question was whether the disablement should be compensated as resulting from the injury or disallowed because it resulted from unauthorized surgery. Once it was determined that the claimant's conduct in undertaking the unauthorized surgery was not unreasonable, the surgery was treated as having resulted from the work injury, and pursuant to the general rule, the consequences of the surgery were accepted as the consequences of the work accident.

Virtually all patients place complete faith in their physicians and, if a physician merely suggests the remote possibility of improvement in a patient's condition through surgery, it cannot be said to be "clearly unreasonable" for the patient to go along with that suggestion. It is irrelevant whether unauthorized surgery was successful or unsuccessful, whether or not the claimant and/or the physician knew the Board was not prepared to authorize the surgery, nor that the surgery was purely exploratory in nature. The only situation where it is foreseeable that the Board could reasonably refuse payment of benefits for unauthorized surgery is where a claimant, in desperation and against the advise of every other physician consulted, deliberately seeks out surgery. Unless the claimant can be shown to have acted foolishly, the claimant should not be deprived of compensation because there happens to be a persuasive surgeon involved who has convinced the claimant that, on balance, surgery is the best course of action. (9)

The above rules only apply where the surgery resulted from the injury. The Board accepts no responsibility for the cost of surgery or any resulting disability where the surgery was not a consequence of the injury.

EFFECTIVE DATE: For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #22.11 of Volume II of this *Manual* regardless of the date of the original work injury or the further injury.

#*22.12 Acceleration of Treatment*

The Board accepts responsibility for all the consequences of treatment where the need for it was accelerated by the injury, even where it would likely have been required at some point in the future in any event. The only exception is where the injury is superimposed on an already existing disability so that Proportionate Entitlement applies. (10)

#22.13 *Activities at Home*

While the Board does pay compensation for injuries arising out of and in the course of medical treatment for a work injury, this does not extend to ordinary exercises performed at home long after the worker has recovered, or the condition has stabilized and the worker is in receipt of a permanent disability pension. Such exercises are usually for the purpose of preventing further problems rather than for treating an existing condition. Compensation is not payable in respect of preventive measures.

#22.14 *Treatment Unrelated to Injury*

Where a worker has to undergo surgery, tests, or other treatment for a non-compensable condition or a non-compensable injury occurs prior to the worker's complete recovery from a compensable injury, and there is for that reason, a delay in recovery or an aggravation of the condition, there are two possible methods for the Claims Adjudicator to deal with the situation. The Adjudicator may, on the one hand, continue to pay wage-loss benefits after the occurrence of the non-compensable injury or treatment for a period which the Adjudicator estimates the worker would have taken to fully recover from the compensable injury if the non-compensable injury or treatment had not occurred. Alternatively, the Adjudicator might immediately terminate benefits on the occurrence of the non-compensable injury or treatment and recommence them when the worker's recovery is at the same stage as it was immediately before its occurrence. Either of these methods may be an appropriate way of dealing with the circumstances of a particular claim. However, in no situation could there be justification for applying both methods to the same claim at the same time, since this would, in effect, result in a double payment to the worker.

The above rule applies though the treatment is carried out at the same time as the treatment for the compensable condition and might not have been carried out at the time if the claimant had not then sought treatment for the compensable condition.

If a compensable injury delays a worker's recovery from subsequent non-compensable surgery, wage-loss compensation may be paid for the period of the delay.

#22.15 *Travelling To and From Treatment*

Injuries arising in the course of normal travel for subsequential treatment are generally not compensable. For example, if a worker suffering from a compensable injury is subsequently injured in the course of travel in the following circumstances, it is not compensable:

(a) attending the office of the attending physician for advice, examination or treatment;

(b) attending for x-ray examinations or laboratory tests when associated with a visit to the office of the attending physician and not involving a special journey from home;

(c) attending the office of a medical specialist in connection with a course of treatments by such a specialist;

(d) attendances at the out-patient department of a hospital, the Board's Rehabilitation Centre or a private physiotherapist for a course of therapy treatments;

(e) travel to a drugstore for the purchase of drugs or other medical supplies;

(f) travel to an optician or optometrist, prosthetist, shoemaker or hearing aid dealer in connection with medical supplies or the fulfillment of prescriptions.

The heading also includes any other types of visits or attendances which are part of a routine (analogous to travelling to and from work) or which are analogous to personal shopping.

Apart from routine travel in connection with subsequential treatment, a worker may sometimes be injured in the course of a special and exceptional journey undertaken as a result of the compensable injury. The following headings illustrate the point.

1. Emergency Transportation

   Where a compensable injury has just occurred and a worker is being transported to a hospital or other place of emergency treatment, and a further injury occurs in the course of such transportation, the further injury is also compensable. This is so whether the worker is travelling on foot, by ambulance, by automobile, by aircraft, or by any kind of vehicle; and it is so regardless of the ownership of the vehicle, and regardless of whether the worker is driving the vehicle or being carried as a passenger.

2. Treatment-Related Vehicles

   If a worker is travelling to or from a place of treatment for a compensable injury and sustains a further injury while travelling in a vehicle that is provided for that purpose by an institution engaged in the provision of treatment, or in the provision of a vehicle for the conveyance of patients for treatment, the injury is compensable.

3. Exceptional Travel for Subsequent Treatment

This heading relates to situations where a worker is travelling by prearranged appointment to a place of exceptional medical treatment, or for an exceptional examination. In these cases, an injury arising out of travel to or from that place of treatment is compensable. The following situations illustrate this point.

(a) Travelling to a hospital for admittance as an inpatient, or travelling home following discharge from hospital as an inpatient.

(b) Travelling to Richmond from the Interior for a course of treatment at the Board's Rehabilitation Centre, with accommodation at the Board's Rehabilitation Residence.

(c) Travelling to any other place of special treatment that involves living away from home for the duration of the treatment.

(d) Travelling in relation to a referral by the attending physician to a specialist for a special examination or treatment.

(e) Travelling for x-ray examination or laboratory tests where this involves a special journey separate from any attendance for routine treatment.

(f) Travelling to a special place of paramedical attention, or a social or rehabilitation agency in connection with assistance in the diagnosis, handling, treatment or care of medical or rehabilitation problems related to the compensable injury on referral by the attending physician, or by the Board.

(g) Travelling on referral by a physician or qualified practitioner to another physician or qualified practitioner for a second opinion.

(h) Travelling for a medical examination at the Board by prearranged appointment with the Board, or for a medical examination elsewhere approved by the Board in connection with a compensable injury.

EFFECTIVE DATE: For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #22.15 of Volume II of this *Manual* regardless of the date of the original work injury or the further injury.

#22.20 Subsequent Injuries Occurring Otherwise than in the Course of Treatment

Where a worker has a pre-existing non-compensable condition which is aggravated and rendered disabling by a work injury, the Board does not deny a claim for compensation just because the injury would have caused no significant problems if there had been no pre-existing condition. The Board accepts that it was the injury that rendered that condition disabling and pays compensation accordingly. The corollary of this is that, where a worker has a compensable condition which is rendered disabling by an aggravating incident occurring outside of work, the worker's claim for the compensable condition is not re-opened just because the incident would not have been significant if that condition had not existed. The Board recognizes rather that it was the non-work incident that produced the disability for which compensation is claimed. The only exception to this is where the compensable condition actually causes the fall or other incident which brought about the aggravation.

Where the subsequent injury occurs at a time when the claimant is still recovering from a previous work injury, the principles set out in #22.14 apply.

#22.21 Activities on Board Premises or at Other Premises under Board Sponsorship

Where a worker is attending at the Board by prearranged appointment made with an officer of the Board for the purpose of an enquiry, interview or discussion in respect of a claim which has been accepted, or which is subsequently accepted, and where the worker suffers a further injury arising out of and in the course of travel to or from such an appointment, the further injury will be compensable.

The same rules apply where a worker is attending by prearranged appointment to meet with the Board's Review Division, the Workers' Compensation Appeal Tribunal or a Medical Review Panel.

Where an injured worker is reinjured while undergoing a course of rehabilitation training sponsored by the Board, the second injury may be regarded as a compensable consequence of the first injury. (11)

EFFECTIVE DATE: For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #22.21 of Volume II of this *Manual* regardless of the date of the original work injury or the further injury.

#22.22 Suicide

In a case of suicide, death benefits are payable if it is established that the suicide resulted from a compensable injury.

In a Board decision, a claim was made by a widow that her husband had committed suicide because of a state of depression and despair resulting from a compensable injury occurring four years earlier. The claim was disallowed. It was possible that the accident might have had some significance. Any adverse experience might have had some significance. But the real test was: Was the suicide something which would have been unlikely to occur if there had been no work accident? On the facts, the suicide was something which might well have occurred in any event rather than something that would have been unlikely without the accident. Bearing in mind the deceased's history of mental disorder and the sparsity of other evidence of causal connections between the work injury and the suicide, it did not appear that the accident had a sufficient degree of causative significance to warrant the conclusion that the death resulted from the compensable injury.

#22.23 Criminal Proceedings

As an example, the claimant, a caretaker of an apartment building, became involved in a fight with a tenant and received injuries for which a compensation claim was accepted. The claimant suffered psychological problems as a result of criminal proceedings taken by the Crown for assault and his employer's suspension of him from his employment pending the outcome of the proceedings. If the charges had not been laid and the claimant had not been suspended, he would not have been disabled. While there was an undeniable link between the actions of the Crown and his employer with the compensable incident, it was too tenuous to make the disability which flows from these actions compensable. The reaction to the laying of charges did not arise out of and in the course of employment, but from the intervening decision of the Crown, a party extraneous to the employer/employee relationship, to proceed with criminal charges. The disability flowing from that decision was not compensable.

#22.30 Diseases or Other Conditions Resulting from Trauma

Compensation coverage extends not just to the immediate physical damage caused by the injury, but to any separate diseases or conditions which arise directly from it.

#22.31 Multiple Sclerosis

While the cause of multiple sclerosis is unknown, there has been much medical literature on factors which may precipitate the onset of the disease in an already predisposed person. One of these factors is a traumatic injury. There is a medical authority for the view that multiple sclerosis may be considered to have been precipitated by a traumatic injury if:

(a) the symptoms and signs of the disease first appeared in the injured part of the body;

(b) the symptoms and signs of the disease occurred shortly after the injury; and

(c) there has been no preceding history of neurologic deficit.

#22.32 Cancer

In claims where trauma is alleged to be the cause of cancer, the following five criteria (12) should be satisfied before a cancer can be even remotely considered to be traumatically induced.

1. Authenticity and adequacy of trauma.

2. Previous integrity of the wounded part.

3. Origin of tumour at exact point of injury.

4. Reasonable time limit between injury and time of appearance of tumour.

5. Positive diagnosis of the presence and nature of the tumour.

Recent reviews of the medical literature have been completed to ascertain whether or not there is new evidence to associate trauma as a causal agent in cancer.

Except in the case of skin cancer, there is little firm evidence to associate trauma with cancer as an etiologic agent. In particular, reviews of several studies (13) of bone cancer fail to establish a causal relationship between trauma and cancer, although there is general recognition of what has been called “traumatic determinism”, i.e. that an injury may call the person’s attention to a pre-existing tumour.

#22.33 Psychological Problems

Psychological problems arising from a physical or psychological injury are acceptable as compensable consequences of the injury. However, there must be evidence that the claimant is psychologically disabled. It cannot be assumed that such a disability exists simply because the claimant has unexplained subjective complaints or is having difficulty in psychologically or emotionally adjusting to any physical limitations resulting from the injury.

When a claim is submitted for psychological problems resulting directly from the claimant’s employment without the occurrence of any physical trauma, reference should be made to #13.20 and #32.10.

When a psychological impairment becomes permanent, it will be necessary to determine whether there is entitlement to a permanent disability pension. The decision-making procedure for assessing entitlement to a permanent disability award for psychological impairment is found in #38.10.

EFFECTIVE DATE: January 1, 2003
APPLICATION: Applies to new claims received and all active claims that are currently awaiting an initial adjudication.

#22.34 Alcoholism and Drug Dependency Problems

Where it is claimed that an alcohol problem may have arisen out of and as a result of a compensable injury, the compensability of the problem is thoroughly investigated in the same manner as followed in investigating the relationship of other problems to an injury. Because of the psychological nature of the problem, this investigation would normally include a reference to a Board Psychologist. The decision on acceptability will however be made by the Claims Adjudicator.

Any pre-existing alcohol problem can be treated in the same way as any other pre-existing condition. The Claims Adjudicator will have to decide whether the claimant's problems are simply a continuation of the previous problems or have been worsened by the injury.

The above procedure would also apply if a claimant whose alcohol problems have previously been accepted by the Board seeks to re-open the claim because of further problems of this type. The request would have to be investigated and if appropriate, a reference made to a Board Psychologist, and a determination made as to whether the current problems are related to the injury and the previous problem, or to some pre-existing condition or other cause.

This policy also has general application in the adjudication of drug dependency problems. For the policy regarding the prescription of narcotics and other drugs of addiction, reference should be made to #77.30.

For the Board's policy toward applications for compensation for alcoholism as an occupational disease, reference should be made to #32.15.

#22.35 Pain and Chronic Pain

A worker's pain symptoms may be accepted as compensable where medical evidence indicates that the pain results as a consequence of a work injury or occupational disease. This policy discusses the scope of coverage in cases where pain is accepted as compensable. Pain is not assessed as a psychological impairment.

1. Definitions:

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. It includes cognitive, affective, behavioural and physiological components.

The Board recognizes three main stages of pain:

i. Acute pain is pain that coincides with a traumatic injury or disease and the early stages of recovery. In the vast majority of cases acute pain eventually resolves, either spontaneously or with some form of treatment.

ii. Subacute pain is pain that an injured worker continues to experience four to six weeks after a traumatic injury or disease.

iii. Chronic pain is pain that persists six months after an injury or occupational disease and beyond the usual recovery time for that injury or disease. Chronic pain is further distinguished as either specific or non-specific as set out in policy item #39.01, "Chronic Pain".

Usual recovery times for injuries or diseases are based on medical protocols and procedures adopted by the Rehabilitation and Compensation Services Division. These medical protocols set out the points in time, after an injury, when a worker should regain pre-accident functional ability, or reach maximum medical recovery.

In determining the appropriate recovery time for an injury, the Board officer may, in consultation with a Board Medical Advisor, consider the medical protocols as well as other factors such as the worker's pre-injury health status and any treatments received that would likely impact the recovery time of the work injury.

2. Early Intervention – Acute and Subacute Pain:

Early intervention involves the provision of early return to work assistance and/or focused multidisciplinary treatment and rehabilitation, to expedite the worker's medical recovery and return to work. Early intervention at the acute or subacute stages of pain is essential as both rehabilitation and prevention measures in deterring the development of chronic pain. Studies indicate that even with some residual or recurrent pain symptoms, workers do not have to wait until they are completely pain free to return to work.

Early intervention should be incorporated into the worker's rehabilitation plan. (See policy item #88.00, "Programs and Services")

(a) Early Return to Work Assistance

In the majority of cases following an injury, a worker is able to return to work shortly after an injury without Board assistance. The provision of early return to work assistance for a worker experiencing acute or subacute pain that is

affecting the worker's return to work efforts will be considered as soon as the worker is medically able to participate. A Board officer will coordinate the worker's early return to work plan in collaboration with the worker, the attending physician, a Board Medical Advisor, the employer and treating clinicians as needed.

In developing an early return to work plan, the Board officer may consider the worker's entitlement to vocational rehabilitation programs and services such as graduated return to work assistance, placement assistance and work site/job modifications where the Board officer concludes that they will assist in a worker's return to work. (See Chapter 11, "Vocational Rehabilitation Services")

(b) Multidisciplinary Treatment and Rehabilitation

In certain cases, the Board officer may consider it appropriate to refer the worker for focused multidisciplinary treatment and/or rehabilitation intervention. These interventions are preferred in cases where the Board officer concludes that they will assist in the worker's early return to work. The Board officer may also consider these interventions where they will assist in preventing the onset of chronic pain.

In making this determination, the Board officer may consult with a Board Medical Advisor and/or a Board Psychologist. The worker's attending physician may also be consulted to confirm his or her agreement with the proposed intervention.

A multidisciplinary approach may include one or more of the following: medical management, physical conditioning, work conditioning, pain and stress management, ergonomic consultation, and vocational counseling and placement.

In determining what specific treatment or rehabilitation intervention is appropriate for a worker, the Board officer may refer the worker for a multidisciplinary assessment. A multidisciplinary assessment is an evaluation of the worker by a physician, a psychologist, a physiotherapist, an occupational therapist, or other provider as the Board determines appropriate.

A multidisciplinary assessment may involve consideration of the worker's medical history, health status, physical limitations, psychological state, behaviour, and workplace issues. The evaluation will provide an opinion on the treatment or rehabilitation intervention, or combination of interventions that would be appropriate to aid in the worker's recovery and return to work.

(c) Early Intervention - Chronic Pain

In all cases where a Board officer considers that a worker may be experiencing chronic pain symptoms, a multidisciplinary assessment must be undertaken. This evaluation will provide an opinion on whether a worker is experiencing chronic pain as a consequence of a compensable injury. The evaluation will also

provide an opinion on the appropriate course of treatment and rehabilitation for the worker.

3. Compensation:

Where a worker is participating in treatment and/or rehabilitation for temporarily disabling pain, a worker's entitlement to temporary wage loss benefits may be considered under section 29 or 30 of the *Act*.

Where chronic pain is considered by the Board officer to become permanent, entitlement to permanent partial disability benefits may be considered under section 23 of the *Act*.

EFFECTIVE DATE: January 1, 2003
APPLICATION: Applies to new claims received and all active claims that are currently awaiting an initial adjudication.

#23.00 REPLACEMENT AND REPAIR OF ARTIFICIAL APPLIANCES, EYEGLASSES, HEARING AIDS, AND DENTURES – SECTION 21(8)

The Board may assume the responsibility of replacement and repair of

(a) artificial appliances, including artificial members damaged or broken as the result of an accident arising out of and in the course of the employment of the worker; and

(b) eyeglasses, dentures and hearing aids broken as a result of an accident arising out of and in the course of employment if that breakage is accompanied by objective signs of personal injury, or, where there is no personal injury, if the accident is otherwise corroborated and the Board is satisfied the worker was not at fault. (15)

In no other circumstances can the Board accept responsibility for damage to a worker's personal possessions.

With the exception of eyeglasses, no compensation for broken appliances, etc. can be paid under the *Government Employees Compensation Act* to employees of the Federal Government unless the breakage resulted from an accident that also caused personal injury. In claims for broken eyeglasses, the adjudication principles used are the same as those which apply under the provincial *Workers Compensation Act*.

#23.10 Meaning of Authority in Section 21(8)

The payment of compensation under Section 21(8) is not a legal right. The section merely confers authority on the Board to pay the compensation provided for. Whether the Board exercises its authority or not is within its discretion. Compensation will be payable in respect of all claims which fall within the terms of the section.

#23.20 Appliances Covered by Section 21(8)

The reference to "eyeglasses" in Section 21(8)(b) includes contact lenses.

Where an injury involves damage to dental crowns and fixed bridgework, they are regarded as part of the natural anatomy for the purpose of adjudication.

Therefore such claims are adjudicated as claims for personal injury under Section 5(1) rather than under Section 21(8).

#23.30 Meaning of Damaged or Broken under Section 21(8)

Section 21(8) refers to items being "damaged" or "broken". However, suppose an accident occurs which causes the loss of a worker's glasses. For instance, they may "fly off" somewhere unknown or be dropped into a place which is inaccessible. Where this follows from an "accident" as defined in #23.40 below, and it is reasonable to assume that, though lost, the worker's glasses are broken, Section 21(8) may be applied as if they are in fact "broken".

#23.40 Meaning of Accident under Section 21(8)

Compensation is not payable under Section 21(8) unless the damage or breakage results from an accident arising out of and in the course of the claimant's employment.

The meaning of "accident" in this section was considered in a Board decision where it was stated:

> "It appears to us that the purpose of Section 21(8) is to provide a form of insurance protection against damage to eyeglasses through chance events. In this case, however, the damage was nothing unexpected. The replacement of eyeglasses in the plant where this occurred is a

predictable routine and part of the normal operating cost of the type of work done by the claimant in that plant. Usually the employer contributes to the replacement of eyeglasses by men working in this situation, and the claim came about only because the claimant required replacement more frequently than the employer regarded as reasonable.

In this situation, the cost of replacing eyeglasses should be regarded as part of the wear and tear of industrial activity rather than being classified as damage by accident."

It should not be concluded from this that if a worker's glasses are broken as a result of a chance event arising out of and in the course of employment, compensation will automatically be payable under Section 21(8). The section is limited to situations where there is a personal injury, the consequences of which include breakage or damage to this apparatus, or there is a direct injury to this apparatus which might also have caused a personal injury. To be an "accident" for the purposes of Section 21(8) a chance event must be such that if it does not actually cause the claimant personal injury, it must have had the potential for doing so. In other words, there must have been a reasonable probability that the accident could have caused the claimant personal injury. No compensation is payable under Section 21(8) if the accident involved the damaged article only and there was no reasonable probability of its harming the claimant.

Consider the following examples:

A. The worker is wearing glasses, or is not wearing them but has them about his or her person, for instance, in a pocket, and they are broken when an object flies into or falls upon them, some harmful liquid splashes onto them, the worker slips and falls to the ground, or bumps his or her head against a wall or some machinery. Even if such an accident does not injure the worker, there is usually an "accident" for the purposes of Section 21(8) as there is usually a reasonable probability that it could have injured the worker.

B. The worker drops his or her glasses, they fall out of a pocket, or off his or her face, or the worker knocks them off when removing clothing or headwear, and they break on impact with the ground or when something falls on them, or the worker takes off the glasses and places them in a position where they are broken. If such an accident does not injure the worker, there is usually not an "accident" for the purposes of Section 21(8) as there is not usually a reasonable probability that it could have injured the worker.

C. Where breakage of eyeglasses falling within Example B. follows immediately after an accident within the meaning of Section 21(8), i.e. one arising out of and in the course of employment which injured or could with reasonable probability have injured the worker, the breakage may be considered to have resulted from this accident. For instance, a worker slips and falls, and the glasses fly off and are run over by a truck, or some harmful liquid splashes into the worker's face and while washing his or her face, the worker places the glasses in a position where they are broken or the glasses are dropped while removed for cleaning. The breakage in these cases might be considered to have resulted from the fall and the splashing of the liquid. The question of whether the worker was at fault would have to be considered.

#23.50 Meaning of Corroboration in Section 21(8)

In the case of eyeglasses, dentures, and hearing aids, where the breakage is not accompanied by objective signs of personal injury, the accident must be corroborated.

Corroboration is evidence other than that of the claimant which renders more probable the truth of the claimant's testimony on a material point. As the Act requires that the accident be corroborated, it is not sufficient for the corroborating evidence simply to confirm the existence of the broken glasses.

Corroboration means that there must be some evidence that is independent of the report or testimony of the claimant. Thus, there is not normally corroboration where the only evidence is the statement of the claimant, coupled with the evidence of another person who had no knowledge of the facts, but is simply able to report a similar statement of the claimant made to the person at an earlier time.

For example, suppose a worker who had just had his or her glasses broken as a result of an accident arising out of and in the course of employment goes immediately to the employer, reports the accident and shows the employer the broken glasses. No matter how shortly after the accident this occurs, a few minutes for instance, the employer's evidence as to this report is corroboration as to the breakage of the glasses, not the accident from which it may have resulted. The employer's evidence as to the occurrence of the accident is not evidence independent of the report or testimony of the claimant.

A possible exception to this rule was recognized in cases where the claimant makes a spontaneous exclamation, or reports an event momentarily after its occurrence so that the immediacy of the report adds to its credibility. This

exception was explained in a Board decision as a reference to what is known in the law of evidence as "res gestae", where the facts speak through the party. More particularly, this means declarations uttered by the claimant simultaneously or almost simultaneously with the occurrence of the accident, so that the declaration forms part of the circumstances of the accident. For example, suppose a worker is hit in the face and the worker's glasses are damaged by a splinter. The worker utters an exclamation of surprise or shock at the moment of impact which indicates that the glasses have been damaged as a result of the accident. This is overheard by someone standing near who did not witness the accident. The repetition of that exclamation by the person who overheard it might amount to corroboration.

Normally corroboration consists of the evidence of witnesses to the accident. Where there are no such witnesses it will, in practice, be very difficult to provide corroboration of an accident's occurrence. It will therefore be very difficult for a person working alone to establish corroboration. However, it may be possible that a lack of witnesses could, in an appropriate case, be remedied by other evidence. This evidence would have to be independent of the report or testimony of the claimant and corroborate the occurrence of the accident as well as the breakage.

In one claim, for instance, the eyeglasses of a nurse in a mental hospital were broken while the nurse was trying to restrain a patient. There were no witnesses to the breakage, but some persons entered the room shortly after to see the glasses broken on the floor and the struggle between nurse and patient continuing. It was considered that the accident was sufficiently corroborated by the witnessing of the struggle. However, if those witnesses had entered after the struggle had ceased the question may be more doubtful. It would probably depend on whether the appearance of the nurse, the patient, and the room, without regard to the nurse's statement as to what happened, made it clear that the struggle had occurred and had resulted in the broken glasses. Obviously, corroboration would be more difficult, the longer after the event the witnesses entered the room.

The above policies and procedures regarding situations where no personal injury occurs also apply to claims administered under the *Government Employees Compensation Act*.

#23.60 Meaning of Fault in Section 21(8)

Where breakage of eyeglasses, dentures, or hearing aids is not accompanied by objective signs of personal injury, not only must the accident causing the breakage be corroborated, but the Board must be satisfied that the worker was not "at fault".

The question of whether the worker was "at fault" arises whenever some negligent or careless act or omission of the worker has contributed to the breakage. However, not all such acts or omissions will result in the worker's being "at fault". In the normal situation, a worker's negligence or carelessness will combine with something in the employment to cause the breakage. Then the question becomes one of weighing the worker's careless act or omission against the employment causes of the damage. If, after weighing these factors, it is considered that the worker's negligence was the predominant cause of the breakage, the worker must be held to be at fault. If, although the worker's negligence contributed to the breakage, it is felt that the predominant cause was something in the employment, the worker is not to be considered at fault.

In weighing the worker's carelessness against any employment causes of the breakage of eyeglasses, it was considered that minor lapses of attention, which it is reasonable to expect from the average worker in the normal course of work, would not generally outweigh the employment aspects of the situation. Therefore, if, for example, a worker trips over or bumps into something in the course of employment, the worker will not usually be held to be at fault because of carelessness in not looking where he or she was going. On the other hand, if, for example, the claimant tripped or bumped into something as a result of horseplay or some other misconduct or unauthorized activity, or had previously been warned about this sort of conduct, such activity might be said to be the predominant cause of any breakage of eyeglasses.

Consider also the example given in #23.40, Example C, of a worker whose glasses are damaged when dropped or taken off following an accident within the meaning of Section 21(8). While the worker might be thought careless in dropping the glasses or placing them in an unsafe place, it was the accident which placed the worker in the situation where it was necessary to take them off, and this put them at risk of being broken as a result of carelessness. Assuming that the worker was not "at fault" in regard to the original accident, it would usually be unfair to regard the worker's carelessness as the predominant cause of the breakage. This would be particularly so if the employment involved the worker in having wet or greasy hands or some other circumstance which would make the worker more prone to drop the glasses or give no opportunity to find a safe place to put them. There may, on the other hand, be cases where the worker's carelessness clearly outweighs the effect of any employment accident.

#23.70 Compensation Payable under Section 21(8)

When a claim satisfies the requirements of Section 21(8), the claimant is reimbursed the amount charged by the supplier or repairer of the appliance in question. The amount payable is not limited to what the Board would pay for a

similar appliance required for a worker as the result of an injury covered by Section 5(1) of the Act.

A claimant is not entitled to wage-loss benefits under Section 21(8) when there is a delay in replacing the broken or damaged appliance and the claimant is unable to work without it. Nor is wage loss payable where the worker has to take off time from work in order to be fitted for new eyeglasses and to pick them up when ready.

#24.00 FEDERAL GOVERNMENT EMPLOYEES

Section 4(1) of the *Government Employees Compensation Act* provides that "compensation shall be paid to . . . an employee who is caused personal injury by an accident arising out of and in the course of his employment . . . and . . . the dependants of an employee whose death results from such an accident." Section 4(4) applies a similar provision to railway employees of the Federal Government. The employees covered by these sections were discussed in #8.10.

The employee or the dependants are, notwithstanding the nature or class of the employment, entitled to receive compensation at the same rate and under the same conditions as are provided under the law of the province where the employee is usually employed. (16)

Compensation entitlement is determined by "the same board, officers or authority as is or are established by the law of the province for determining compensation for workmen and dependants of deceased workmen" other than Federal employees. (17)

The phrase "by an accident" in Subsection 4(1) does not require that there be a clearly ascertainable incident or series of incidents which caused the injury. Injuries that arise gradually over time or "by process" are not excluded by this subsection. The injury itself can be the "accident" for the purpose of Section 4. Thus, the test for Federal employees in B.C. under Subsection 4(1) is, in effect, the same as the test for other workers in B.C. under Subsection 5(1) of the B.C. Act. (18)

The *Government Employees Compensation Act* applies to an accident occurring or a disease contracted within or outside Canada. (19)

For the purposes of the *Government Employees Compensation Act*, the place where an employee is usually employed is the place where the employee is appointed or engaged to work.

Where an employee is usually employed in the Yukon Territory or the Northwest Territories, the employee is deemed to be usually employed in the Province of Alberta. (20)

Where an employee, other than a person locally engaged outside Canada, is usually employed outside Canada, the employee is deemed to be usually employed in the Province of Ontario. (21)

NOTES

(1) Appeal Division Decision No. 92-0743; #24.00

(2) See #13.12

(3) *Law of Workmen's Compensation*, A. Larson, 1972, Vol. I, para. 23.61

(4) See #2.23

(5) Larson, para. 25.00

(6) See #19.31
(7) See #19.31
(8) See #21.10
(9) See #78.11
(10) See #44.00
(11) See #88.54 and #115.30
(12) Ewing, J. Modern attitude toward traumatic cancer. *Arch. Path.* 19:690-728, 1935
(13) Pritchard et al. The Etiology of Osteosarcoma. *Clin. Orthoped. and Rel. Res.* 111:14-22, September 1975;
Coley, W.B. *Neoplasms of Bone.* Paul Haber Inc., 2nd ed., 1960;
Dahlin, David C. *Bone Tumours*. Charles C. Thomas, 3rd ed., 1978;
Monkman et al. Trauma and Oncogenesis. *Mayo Cl. Proc.* 49:157-163, March 1974
(14) ~~See Chapter 5~~ DELETED
(15) S.21(8)
(16) *Government Employees Compensation Act*, S.4(2)
(17) *Government Employees Compensation Act*, S.4(3)
(18) Appeal Division Decision No. 92-0743
(19) *Government Employees Compensation Act*, S.3(2)
(20) *Government Employees Compensation Act*, S.5
(21) *Government Employees Compensation Act*, S.6

CHAPTER 4

COMPENSATION FOR OCCUPATIONAL DISEASE

#25.00 INTRODUCTION

Section 6 of the *Workers Compensation Act* provides that compensation is payable for occupational disease that is due to the nature of a worker's employment. Section 7 provides that compensation is payable for a certain level of non-traumatic noise-induced hearing loss that results from a worker's employment. This chapter deals with such compensation.

Most compensation cases involve a personal injury (covered in Chapter 3) where it can readily be determined whether the event or series of events leading to such injury arose out of and in the course of employment. The cause of disease, by its nature, is often more difficult to determine. A common difficulty is distinguishing between an injury and a disease (the difference is discussed in #13.10). Even when medical science has identified the cause of a disease in a general sense, it may be difficult to establish with any degree of certainty how and when a worker contracted or developed a disease. Further, workers' compensation does not extend to all diseases, rather only to those that are due to a worker's employment. In these circumstances, determining the extent to which a worker's employment had in producing the disease becomes a critical or central issue.

The question is: was the worker's disability caused by his or her work or by something else such as the operation of natural causes, or by congenital or hereditary disease. The *Workers Compensation Act* provides different ways of dealing with this issue. These are discussed in this chapter.

#25.10 Legislative Requirements

Section 6(1) provides:
"Where

(a) a worker suffers from an occupational disease and is thereby disabled from earning full wages at the work at which the worker was employed or the death of a worker is caused by an occupational disease; and

(b) the disease is due to the nature of any employment in which the worker was employed, whether under one or more employments,

compensation is payable . . . as if the disease were a personal injury arising out of and in the course of that employment. A health care benefit may be paid although the worker is not disabled from earning full wages at the work at which he or she was employed."

For the diseases to which Section 6(1) of the Act apply, there are three basic requirements for compensability:

1. The worker must be suffering (or in the case of a deceased worker have suffered) from a disease designated or recognized by the Board as an "occupational disease";
2. The disease suffered by the worker must be or have been "due to the nature of any employment" in which the worker was employed; and
3. The worker must be "disabled from earning full wages at the work" at which he or she was employed as a result of the disease. In the case of a deceased worker, his or her death must have been caused by such disease. This is discussed further in #26.30. This third requirement does not apply to claims for silicosis, asbestosis, or pneumoconiosis (see #29.40) or to claims for non-traumatic noise-induced hearing loss to which Section 7 of the Act apply. Further, a worker need not be disabled by the disease in order to be entitled to health care benefits.

These elements of Section 6 are discussed further in the following sections. The definition of "worker" is covered in Chapter 2.

A disease which is attributed to or is the consequence of a specific event or trauma, or to a series of specific events or traumas, will be treated as a personal injury and will be adjudicated in accordance with the policies set out in Chapter 3.

#26.00 THE DESIGNATION OR RECOGNITION OF AN OCCUPATIONAL DISEASE

Section 1 of the Act defines "occupational disease" as

> "any disease mentioned in Schedule B, and any other disease which the board, by regulation of general application or by order dealing with a specific case, may designate or recognize as an occupational disease, and "disease" includes disablement resulting from exposure to contamination" (emphasis added).

There are a great many diseases to which the general public are subject, many of which can be considered ordinary diseases of life. Available medical and scientific understanding about the causes of disease and about the role that employment may play covers a wide range from very good to very poor. Not every disease contracted by every worker is compensable. Deciding when they are is key to the operation of the Act and to adjudicating individual disease claims. It is within this context that decisions must be made as to the compensability of diseases, suffered by workers who are covered by the Act.

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 policy items #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, meritorious, 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 a reviewable decision. The Adjudicator shall advise the Manager 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.

The Manager, upon receipt of a recommendation from the Adjudicator for recognition of the worker's condition as an occupational disease, and after considering and discussing the claim file with the Medical Advisor and after completing any further investigations which he or she considers appropriate, will determine whether the condition reported is one which should be recognized by the Board as an occupational disease for the purposes of that claim. If so, he or she will make an order to that effect which is recorded on the claim file. The Manager will keep a record of all such referrals under this section.

If, after considering a referral under this section, the Manager concludes that the reported condition might not be recognized as an occupational disease, the Manager will first advise the worker (or in the case of a deceased worker, their legal representative) and give him or her an opportunity to respond. A decision of the Manager not to recognize the condition as an occupational disease for the purposes of that claim is a reviewable decision.

Where the Manager makes an order to recognize the condition as an occupational disease for the purposes of that claim, the claim is returned to the Adjudicator who will determine all other relevant issues, including whether the worker is entitled to benefits provided for under the *Act*. The making of such an order by the Manager is a reviewable decision.

Where the Manager is not the Client Services Manager, Occupational Disease Services, he or she will ensure that the Client Services Manager, Occupational Disease Services is provided with written notice of any decisions under policy item #26.04.

The designation or recognition of an occupational disease by inclusion in Schedule B, under section 6(4)(b), or by regulation, does not preclude its recognition by order dealing with a specific case if it occurred prior to its designation or recognition by one of the other alternate methods.

EFFECTIVE DATE: October 1, 2007 – Revised to delete references to memos and memorandums.

HISTORY: March 3, 2003 – consequential changes as to references to review

APPLICATION: Applies on or after October 1, 2007

#26.10 Suffers from an Occupational Disease

Part of the first requirement for compensability is that the worker suffers from, or in the case of a deceased worker the death was caused by, an occupational

disease. Confirming the diagnosis of many occupational diseases may be difficult. This is particularly so for poisoning by some of the metals and compounds listed in Schedule B, the symptoms of which may be similar to the symptoms caused by common complaints that produce fatigue, nausea, headache and the like.

In one Board decision, a worker was advised by the attending physician that he was suffering from lead poisoning and should temporarily withdraw from work. The Board concurred with that advice. Laboratory testing done one month later led to a conclusion that initial tests had been wrong and that the worker never did have lead poisoning. The Board concluded that in these circumstances, where the worker acted reasonably in reliance on medical advice that the Board agreed with, the merits and justice of the claim warranted a conclusion that the worker was suffering from an occupational disease at the time in question even though in retrospect this was proven not to be the case. (2) The cost of compensation paid on a claim of this type is excluded from the employer's experience rating (see #113.10).

#26.20 Establishing Work Causation

The fundamental requirement for a disease to be compensable under Section 6(1) of the *Workers Compensation Act* is that the disease suffered by the worker is "due to the nature of any employment in which the worker was employed whether under one or more employments".

There are two approaches to establishing work causation.

#26.21 Schedule B Presumption

Section 6(3) provides:

> "If the worker at or immediately before the date of the disablement was employed in a process or industry mentioned in the second column of Schedule B, and the disease contracted is the disease in the first column of the schedule set opposite to the description of the process, the disease is deemed to have been due to the nature of that employment unless the contrary is proved."

The primary significance of Schedule B is with its use as a means of establishing work causation.

The fundamental purpose of Schedule B is to avoid the repeated effort of producing and analyzing medical and other evidence of work-relatedness for a disease where research has caused the Board to conclude that such disease is specific to a particular process, agent or condition of employment (see #26.01). Once included in Schedule B, it is presumed in individual cases that fit the

disease and process/industry description that the cause was work-related. A claim covered by Schedule B can be accepted even though no specific evidence of work relationship is produced. A review of the available medical and scientific evidence would establish a likely relationship between the disease and the employment. The listing in the Schedule avoids the effort of producing the evidence in every case. Where the research does not clearly relate the disease to particular employments, the disease is not listed in Schedule B and the issue of work-relatedness must be determined on a case-by-case basis (see #26.22).

If at the time a worker becomes disabled by a disease listed in Schedule B, or if immediately before such date, such worker was employed in the process or industry described in the second column of the Schedule opposite to such disease, the worker is entitled to a presumption that the disease was caused by their employment, "unless the contrary is proved". This presumption applies whether the disease manifests itself while the worker is at work, at home, while away on holidays, or elsewhere. The words "immediately before" used in Section 6(3) are intended to deal with those situations where someone has been employed in the process or industry described in the Schedule, and has left that employment a very short time prior to the onset of the disease.

If a worker becomes disabled by a disease listed in Schedule B but at the relevant time had not been employed in the process or industry described in the Schedule, the claim may still be an acceptable one, however no presumption in favour of work-relatedness would apply. In this event establishing work causation follows the approach covered in #26.22.

Inclusion of the words "unless the contrary is proved" in Section 6(3) means that the presumption is rebuttable. Even though the decision-maker need not consider whether working in the described process or industry is likely to have played a causative role in giving rise to the disease, they must still consider whether there is evidence which rebuts or refutes the presumption of work-relatedness.

The standard of proof to be applied in determining whether the presumption has been rebutted is proof on a balance of probabilities. This is the same basic standard of proof applicable in the workers' compensation system. If the evidence is more heavily weighted in favour of a conclusion that it was something other than the employment that caused the disease, then the contrary will be considered to have been proved and the presumption is rebutted. The gathering and weighing of evidence generally is covered in #97.00 through #97.60.

Difficulties may arise in determining whether the worker was employed in the process or industry described in the second column. This often arises because of the use of such words as "excessive" or "prolonged". While the Board would

like to define more precisely the amount and duration of exposure required instead of using these words, it is usually not possible. The exact amounts will often vary according to the particular circumstances of the work place and the worker, or may not be quantified with sufficient precision by the available research. However, while such words are of uncertain meaning, there is valid reason for inserting them. Individual judgment must be exercised in each case to determine their meaning, having regard to the medical and other evidence available as to what is a reasonable amount or duration of exposure.

EFFECTIVE DATE: June 1, 2004
APPLICATION: All decisions, including appellate decisions, made on or after June 1, 2004.

#26.22 Non-Scheduled Recognition and Onus of Proof

In some cases a worker may suffer an occupational disease not listed in Schedule B. In other cases a worker may suffer from an occupational disease listed in Schedule B but was not employed in the process or industry described opposite to it in the Schedule. In some cases a worker may suffer a disease not previously designated or recognized by the Board as an occupational disease. Here, the decision on whether the disease is due to the nature of any employment in which the worker was employed, is determined on the merits and justice of the claim without the benefit of any presumption. The same is true if for any other reason the requirements of section 6(3) are not met.

For this purpose the Adjudicator will conduct a detailed investigation of the worker's circumstances including information about the worker, their diagnosed condition, and their workplace activities. The Adjudicator is seeking to gather evidence that tends to establish that there is a causative connection between the work and the disease. The Adjudicator will also seek out or may be presented with evidence which tends to show there is no causative connection. The gathering and weighing of evidence generally is covered in policy items #97.00 through #97.60. The Adjudicator is to examine the evidence to see whether it is sufficiently complete and reliable to arrive at a sound conclusion with confidence. If not, the Adjudicator should consider what other evidence might be obtained, and must take the initiative in seeking further evidence. After that has been done, if, on weighing the available evidence, there is then a preponderance in favour of one view over the other, that is the conclusion that must be reached. Although the nature of the evidence to be obtained and the weight to be attached to it is entirely in the hands of the Adjudicator, to be sufficiently complete the Adjudicator should obtain evidence from both the worker and the employer, particularly if the Adjudicator is concerned about the accuracy of some of the evidence obtained.

Since workers' compensation in British Columbia operates on an inquiry basis rather than on an adversarial basis, there is no onus on the worker to prove his or her case. All that is needed is for the worker to describe his or her personal

experience of the disease and the reasons why they suspect the disease has an occupational basis. It is then the responsibility of the Board to research the available scientific literature and carry out any other investigations into the origin of the worker's condition which may be necessary. There is nothing to prevent the worker, their representative, or physician from conducting their own research and investigations, and indeed, this may be helpful to the Board. However, the worker will not be prejudiced by his or her own failure or inability to find the evidence to support the claim. Information resulting from research and investigations conducted by the employer may also be helpful to the Board.

As stated in policy item #97.10, a worker is also assisted in establishing a relationship between the disease and the work by section 99 of the *Act* that provides:

> (1) The Board may consider all questions of fact and law arising in a case, but the Board is not bound by legal precedent.
>
> (2) The Board must make its decision based upon the merits and justice of the case, but in so doing the Board must apply a policy of the board of directors that is applicable in that case.
>
> (3) If the Board is making a decision respecting the compensation or rehabilitation of a worker and the evidence supporting different findings on an issue is evenly weighted in that case, the Board must resolve that issue in a manner that favours the worker.

Therefore if the weight of the evidence suggesting the disease was caused by the employment is roughly equally balanced with evidence suggesting non-employment causes, the issue of causation will be resolved in favour of the worker. This provision does not come into play where the evidence is not evenly weighted on an issue.

If the Board has no or insufficient positive evidence before it that tends to establish that the disease is due to the nature of the worker's employment, the Board's only possible decision is to deny the claim.

EFFECTIVE DATE: March 3, 2003 (as to new wording of section 99)
APPLICATION: Not applicable.

#26.30 Disabled from Earning Full Wages at Work

No compensation other than health care benefits are payable to a worker who suffers from an occupational disease (with the exception of silicosis, asbestosis, or pneumoconiosis and claims for hearing loss to which Section 7 of the Act apply) unless the worker "is thereby disabled from earning full wages at the work at which the worker was employed". (3) No compensation is payable in respect

of a deceased worker unless his or her death was caused by an occupational disease (also see Section 6(11) of the Act).

Health care benefits may be paid to a worker who suffers from an occupational disease even though the worker is not thereby disabled from earning full wages at the work at which he or she was employed.

There is no definition of "disability" in the Act. The phrase "disabled from earning full wages at the work at which the worker was employed" refers to the work at which the worker was regularly employed on the date he or she was disabled by the occupational disease. This means that there must be some loss of earnings from such regular employment as a result of the disabling affects of the disease, and not just an impairment of function. For example, disablement for the purposes of Section 6(1) may result from:

- an absence from work in order to recover from the disabling affects of the disease;
- an inability to work full hours at such regular employment due to the disabling affects of the disease;
- an absence from work due to a decision of the employer to exclude the worker in order to prevent the infection of others by the disease;
- the need to change jobs due to the disabling affects of the employment.

A worker who must take time off from his or her usual employment to attend medical appointments is not considered disabled by virtue of that fact alone. However, income loss payments may be made to such a worker (see #83.13).

A change of employment or lay-off from work for the purpose of precluding the onset of a disability does not amount to a disability for this purpose.
For time limits with respect to occupational disease claims see #32.55.

#26.50 Natural Degeneration of the Body

It often happens that disability results from the natural aging process. At times the pace of the process and each aspect of it can be influenced by environmental circumstances and activity. Work, leisure activities, genetic factors, air purity, diet, medical care, personal hygiene, personal relations and psychological make-up are all factors that may influence the pace of many kinds of natural degeneration. Where the degeneration is of a kind that affects the population at large, it is difficult for the Board to attempt a measurement of the significance of each occupation on each kind of degeneration. It is also difficult to determine whether a particular occupation had any significant effect in advancing the pace of degeneration compared with other occupations, or compared with a life of leisure. Where a degenerative process or condition is of a kind that affects the population at large, it will not be designated or recognized by the Board as an occupational disease unless employment causation can be established.

If a worker is suffering from a kind of bodily deterioration that affects the population at large, it is not compensable simply because of a possibility that work may be one of the range of variables influencing the pace of that degeneration. For the disability to be compensable, the evidence must establish that the work activity brought about a disability that would probably not otherwise have occurred, or that the work activity significantly advanced the development of a disability that would otherwise probably not have occurred until later.

For example, osteoarthritis in the spine, rheumatoid arthritis, and degenerative disc disease have not been designated or recognized under #26.01, #26.02, or #26.03 as occupational diseases. (4), (5)

#26.55 Aggravation of a Disease

Where a worker has a pre-existing disease which is aggravated by work activities to the point where the worker is thereby disabled, and where such pre-existing disease would not have been disabling in the absence of that work activity, the Board will accept that it was the work activity that rendered the disease disabling and pay compensation. Evidence that the pre-existing disease has been significantly accelerated, activated, or advanced more quickly than would have occurred in the absence of the work activity, is confirmation that a compensable aggravation has resulted from the work.

This must be distinguished from the situation where work activities have the effect of drawing to the attention of the worker the existence of the pre-existing disease without significantly affecting the course of such disease. For example, a worker who experiences hand or arm pain due to an arthritis condition affecting that limb will not be entitled to compensation simply because they experience pain in that limb from performing employment activities. Similarly, a worker with a history of intermittent pain and numbness in a hand/wrist due to a pre-existing

median nerve entrapment (carpal tunnel syndrome) will not be entitled to compensation just because their work activities also produce the same symptoms. To be compensable as a work-related aggravation of a disease, the evidence must establish that the employment activated or accelerated the pre-existing disease to the point of disability in circumstances where such disability would not have occurred but for the employment.

Where the pre-existing disease was compensable, the Adjudicator must decide if the aggravation should be treated as a new claim or as a reopening of an earlier claim.

An aggravation of a pre-existing disease which is attributed to a specific event or trauma, or to a series of specific events or traumas, will be treated as a personal injury and will be adjudicated in accordance with the policies set out in Chapter 3. For example, a worker who injures his or her back while performing a series of awkward lifts at work may suffer an aggravation to an underlying degenerative disc disease, or a worker with subacromial bursitis may strain the shoulder while completing a particular lift.

An aggravation of a pre-existing disease which is not attributed to a specific event or trauma, or to a series of specific events or traumas, will be treated as a disease. For example, a worker with a prior history of carpal tunnel syndrome may aggravate such condition to the point of requiring surgery as a result of several weeks of exposure to vibrating equipment.

Where a compensable aggravation of a pre-existing disease occurs, consideration will be given to relief of costs under Section 39(1)(e) of the Act and to Section 5(5) of the Act. (See #114.40.)

#26.60 Amending Schedule B

Section 6(4)(a) of the *Workers Compensation Act* provides:

> "The board may, on the terms and conditions and with the limitations the board deems adequate and proper, add to or delete from Schedule B a disease which the board deems to be an occupational disease, and may in like manner add to or delete from the said Schedule a process or industry."

This provision gives the Board substantial flexibility in its ability to add to or delete from the list of diseases designated or recognized in Schedule B, and to impose whatever terms, conditions or limitations it considers appropriate in

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);

- the distance the tool or work object is moved;
- the speed at which the tool or work object is moved (extra force may be needed to start or stop moving objects);
- the amount of friction that exists between the tool or work object and the worker's hand (slippery tools may require greater force to grip) or between the tool or work object and other surfaces (greater force may be required to overcome that friction);
- whether tools or work objects are handled using a pinch grip or a power grip (pinch grips exert more force on the tendons of the thumb and fingers);
- whether sustained force must be applied (after an initial force is applied);
- whether the tool or work object is vibrating (greater force may be required to control a vibrating object).

Other evidence may be relevant to determining whether there was "forceful exertion" in the circumstances of the individual claim.

Significant component of the employment

Use in Schedule B item 13(a) of the words "where such activity represents a significant component of the employment" means that the worker has been exposed to the processes described in paragraphs (1), (2), and/or (3) of item 13(a) for sufficiently long that it is biologically plausible that the hand-wrist tendinitis/tenosynovitis has resulted from the work activities. Employment activities that have involved minimal or trivial use of the hand-wrist as described in item 13(a) do not amount to "a significant component of the employment".

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

Shoulder tendinitis

The policies set out in #27.11 dealing with interpreting the terms "frequently repeated…abduction or flexion of the shoulder joint", "sustained abduction or flexion of the shoulder joint", and "significant component of the employment" apply in interpreting those terms used in Schedule B item 13(b).

#27.13 Hand-Arm Vibration Syndrome (HAVS)

Schedule B lists "Hand-arm vibration syndrome" as an occupational disease. The process or industry described opposite to it is "Where there has been at least 1000 hours of exposure to tools or equipment which cause the transfer of significant vibration to the hand-arm of the claimant". This listing covers the

condition also known as vibration-induced Raynaud's phenomenon or vibration-induced white finger (VWF).

Operators of vibratory tools or equipment may develop physiologic changes induced by that vibration. These tools and equipment include, but are not limited to, chainsaws, pneumatic drills, impact wrenches, chipping hammers, grinders, jackhammers, and polishers. Initial symptoms of these physiologic changes may include persistent numbness and tingling, swelling and/or blanching of the fingers.

The following represents a list of the most important risk factors relevant to the adjudication of all claims for Hand-arm vibration syndrome.

dose:

This is the most important risk factor in the development of HAVS. It is a function of both the level or intensity of the vibration and the duration or length of time exposed to that vibration. It is generally considered that frequencies in the range of 5 to 1500 cycles per second can be hazardous. Intensity is usually measured by the level of acceleration of the vibrating tool (the time rate of change of the speed of the vibrating object measured in metres per second per second, or m/sec^2). The greater the dose of vibration (the greater the acceleration of the vibrating tool and/or the greater the cumulative hours of exposure to the vibration) the lower is the latency period measured from the time of first exposure to the vibration and the onset of symptoms of Hand-arm vibration syndrome.

In order for the presumption to apply in the case of HAVS, there must have been at least 1000 hours of exposure. It should be noted, however, that the condition could occur with exposures less than 1000 hours if the intensity of the exposure is significant. Such cases must be considered on their own merits.

Use of the words "significant vibration" in Schedule B is a recognition that the intensity of vibration experienced by the worker must be significant for the presumption in favour of work causation to apply. Individual judgment must be exercised in each case to determine whether exposure to significant vibration has occurred having regard to the evidence available.

nature of exposure:

Continuous exposure to vibration may increase the risk of developing Hand-arm vibration syndrome when compared to exposure to vibration which is interrupted by rest periods (e.g. 10 minutes of rest during each hour of exposure).

grip force:

The greater the grip force used to grasp the vibrating tool or equipment, the more efficient is the transfer of vibration energy to the hand-arm of the worker and the greater the risk that physiologic changes will occur. For some tools the greater the intensity of the vibration, the greater will be the grip force required to control the tool.

protective equipment:

Anti-vibration gloves may absorb some of the higher frequencies (above 500 cycles per second) and allow workers to maintain hand temperatures and to prevent calluses. Conventional glove designs do little to absorb frequencies below 500 cycles per second. Some of these gloves may actually amplify lower frequencies.

individual susceptibility:

Workers with pre-existing conditions such as connective tissue diseases or vascular diseases may be more susceptible to vibration-induced physiologic changes that may result in Hand-arm vibration syndrome.

In order to conclude that a worker suffers from hand-arm vibration syndrome, it must be concluded that the worker does not suffer from primary Raynaud's disease (which is a recognized clinical entity that has no known cause) or from other non-vibration induced causes of secondary Raynaud's phenomenon. These include, but are not limited to, collagen vascular disease, peripheral vascular disease, or peripheral neuropathies such as carpal tunnel syndrome. The presence or absence of these conditions should be commented upon by the physician who has assessed the worker.

Most compensable injuries and diseases involve an initial period of temporary disability during which temporary total or temporary partial disability benefits are paid. The physical impairment of the worker will usually improve in time until it disappears entirely or becomes permanent. However, in the case of some diseases, there is no initial period of temporary disability; the disability is permanent right from the time it first becomes manifest as a disability and no temporary disability benefits are payable. Hand-arm vibration syndrome is one of these diseases. There are also others. For example, hearing loss caused by exposure to occupational noise. Permanent disability awards are payable in respect of the disabilities caused by these diseases only once a specified minimum level of impairment is reached. Temporary disability benefits are payable in those rare cases where a period of temporary disability results from the disease.

Where a worker claims to have developed a disorder affecting one or both feet as a result of exposure to vibration, such as from standing on a vibrating platform or in vibrating machinery, such claim may be classified either as an injury or a disease, depending on the circumstances (see #13.12 and #27.34). Where such worker claims to have experienced a gradual deterioration in their feet due to exposure to vibration over time, such claim will be treated as an occupational disease. "Disablement from vibrations" has been designated or recognized as an occupational disease by regulation (see #26.03). Such a claim must be considered on its own merits (without the benefit of any presumption).

#27.14 Hypothenar Hammer Syndrome

Hypothenar hammer syndrome has been designated or recognized as an occupational disease by regulation (Section 1 of the Act).

This condition is due to repeated blunt trauma to the ulnar border of the affected hand. It will often occur in workers who use their bare hand as a hammer in order to strike or pound hard objects. The area of the hand where contact is made is usually the hypothenar eminence. Repeated blows to this ulnar portion of the hand can result in thrombosis or aneurysm formation in the branches of the ulnar artery, which in turn can produce a painful lump in the hypothenar area and/or numbness in the fourth or fifth fingers.

There are a number of non-occupational activities which may involve repeated blunt trauma to the ulnar border or other parts of the hand (for example, participation in some martial arts or self defense activities, certain sports, such as handball and baseball catcher, or playing certain percussion instruments). In the investigation of a claim for hypothenar hammer syndrome the adjudicator will determine how and to what extent the worker uses the affected hand in striking or pounding objects in both the occupational and non-occupational settings.

Each claim must be determined according to its own merits. If the evidence in a particular claim indicates that there are factors suggesting both an occupational and non-occupational cause for the hypothenar hammer syndrome, the decision on the claim can only be a judgment one makes in the particular circumstances by weighing the evidence.

#27.20 Tendinitis/Tenosynovitis and Bursitis Claims Where No Presumption Applies

This Section deals with claims where the worker has tendinitis/tenosynovitis or bursitis, but was not at the relevant time "employed in a process or industry mentioned in the second column of Schedule B".

A claim for compensation will be accepted for a worker who suffers from a disease designated or recognized by the Board as an occupational disease which the evidence establishes as having resulted from employment covered by the Act. Where a worker suffers from an occupational disease listed in Schedule B but was not employed in the process or industry described opposite to the disease in the second column of Schedule B, that simply means that there is no presumption of work causation. In that event, the Adjudicator must still determine on the evidence whether the disease was due to the nature of the employment under Section 6(1) of the Act.

The requirements of the second column of Schedule B are not preconditions or limitations to the acceptance of a claim. There may be other evidence supporting the conclusion that the disease is due to the nature of the worker's employment. It also follows that the requirements of the second column of Schedule B are not the only matters to be considered for that disease in the adjudication of the claim. It is only where the presumption applies that it may be unnecessary to consider such other matters because work causation will already have been established. Additionally there may be situations where the nature of the work activity is such as would ordinarily raise a likelihood of work causation, but there exists other evidence, which suggests a contrary conclusion. For example, both wrists may be affected by the same condition but the worker only ever used one wrist in performing the work, or the worker may be suffering from an underlying disease which itself is capable of producing the condition for which the claim is made (such as rheumatoid arthritis producing a wrist tendinitis). The decision in such a case can only be a judgement one makes by weighing the evidence for and against work causation. An assessment of risk factors related to the employment will normally be the most important consideration in these types of claims. However, this is not the only consideration. Non-occupational risk factors may exist relative to the claim, which tend to refute the conclusion which might ordinarily be suggested by an assessment of the work activity. For a discussion of risk factors see #27.40.

In the investigation of a claim for tendinitis/tenosynovitis or bursitis (in circumstances where no presumption applies) it is incumbent on the Adjudicator to seek out evidence of both occupational and non-occupational exposure to risk factors relevant to the causation of the disorder (see #26.21 regarding the approach when a presumption applies). Non-occupational exposures may be present as a result of participating in sports, hobbies, or certain ordinary activities of daily living. The compensability of such a claim depends on whether or not the employment activities (the occupational exposure to risk factors) played a significant role in producing the inflammatory disorder. The occupational exposure need not be the sole or even the predominant cause; it simply needs to have been a significant cause.

Although the risk of developing tendinitis/tenosynovitis or bursitis may be significantly greater where, in the performance of work tasks, two or more risk factors are present at the same time, these inflammatory disorders may result from a particularly frequent, intense or prolonged exposure to a single risk factor. Even though work causation may not be established by virtue of applying the presumption set out in Section 6(3) of the Act, the Adjudicator may conclude that exposure to a single risk factor (whether described in the second column of Schedule B or not) played a significant role in producing the tendinitis/tenosynovitis or bursitis, and that accordingly the claim meets the requirements of Section 6(1) of the Act.

In assessing whether or not a tendinitis/tenosynovitis or bursitis condition is due to the nature of a worker's employment, in circumstances where there is evidence of both occupational and non-occupational exposure to risk factors (relevant to the causation of these inflammatory disorders), consideration is given to such matters as:

- the relative frequency, intensity, and duration of exposure to risk factors encountered in connection with the worker's employment compared to those encountered in non-occupational activities;
- whether the intensity of the forces placed on the affected tissues in connection with the worker's employment activities are likely to produce injury (such as a sudden stretching of tendinous tissues) when compared to such likelihood arising from the intensity of forces encountered in connection with the worker's non-occupational activities;
- the likelihood that the worker's occupational and non-occupational activities may have acted together in the development of the inflammatory disorder in circumstances where the inflamed tissues have had insufficient time to return to a relaxed or resting state due to the combined effects of these activities;
- whether any changes took place in either the employment activities or the non-occupational activities prior to or at the time of onset of symptoms of the inflammatory disorder, noting that performing unaccustomed activities may significantly increase the risk (see reference to "unaccustomed activity" in #27.40);
- whether there is evidence of similar inflammatory disorders occurring in other workers who perform the same type of tasks as those performed by the worker, and whether there is evidence of such disorders occurring in the general population among those who are engaged in the same type of non-occupational activities as those in which the worker is engaged;

- the likelihood that the worker's combined employment activities (where the worker has more than one employment) may have acted together in the development of the inflammatory disorder in circumstances where the inflamed tissues have had insufficient time to return to a relaxed or resting state due to the combined effects of those activities;
- whether the worker has previously suffered injuries, inflammation, or infections associated with the affected tissues, and if so the likely cause of these prior conditions;
- whether there is evidence of a disorder (such as a degenerative tear or infection) at or near the site of the subject condition;
- whether the worker has suffered from any degenerative or systemic disorders (including but not limited to degenerative arthritis, rheumatoid arthritis, gout, systemic lupus erythematosus, connective tissue disease, or inflammatory rheumatological disorder), and if so whether such underlying disorder is the likely cause of the subject inflammatory disorder, or alternatively has had the effect of rendering the worker more susceptible such that shorter, or less frequent, or less intense exposure to risk factors may initiate the subject disorder;
- whether the worker is taking prescription medications, is undergoing any therapy or treatment for any other condition, or is pregnant, and if so whether this is a likely cause of the subject disorder or alternatively has had the effect of rendering the worker more susceptible.

#27.30 ASTDs Recognized by Regulation

The following disorders which may be caused or aggravated by employment activities have been designated or recognized as occupational diseases by regulation (Section 1 of the Act):

- epicondylitis, lateral and medial
- carpal tunnel syndrome
- cubital tunnel syndrome
- radial tunnel syndrome
- thoracic outlet syndrome
- stenosing tenovaginitis (trigger finger)
- disablement from vibrations

As with other diseases recognized by regulation, there is no presumption in favour of causation. These diseases are compensable only if the evidence establishes in the particular case that the disease is due to the nature of any employment in which the worker was employed. These diseases are discussed in further detail in #27.31 through #27.34.

#27.31 Epicondylitis

Epicondylitis is a localized inflammation of the muscle and tendon where they attach to the bone (epicondyles) at either side of the elbow. Inflammation on the lateral side is lateral epicondylitis (sometimes called tennis elbow) and on the medial side is medial epicondylitis (sometimes called golfer's elbow). Medical/scientific research on epicondylitis does not as a whole confirm a strong association with employment activities and its mechanisms of development are obscure. Some individual studies do indicate an excess incidence of epicondylitis in employments with tasks strenuous to the muscle-tendon structures of the arm. One often referred to theory suggests that microtears at the attachment of the muscle to the bone may be due to repetitive activity with high force sufficient to exceed the strength of the collagen fibres of the tendon attachment. This in turn may lead to the formation of fibrosis and granulation tissue.

As the research does not clearly relate epicondylitis to any particular employments, each claim must be determined according to its own merits.

The Board recognizes that where the worker was occupationally performing frequent, repetitive, forceful and unaccustomed movements (including forceful grip) of the wrist that are reasonably capable of stressing the inflamed tissues of the arm affected by epicondylitis, and in the absence of evidence suggesting a non-occupational cause for the worker's epicondylitis condition, a strong likelihood of work causation will exist. These factors are not preconditions to the acceptance of a claim for epicondylitis nor are they the only factors which may be relevant. For example, lateral epicondylitis has been shown to occur in tennis players (some studies showing a strong causative association) who are well accustomed to the motions and forces involved. The issue to be determined in any individual claim is whether the evidence leads to a conclusion that the epicondylitis is due to the nature of the worker's employment.

#27.32 Carpal Tunnel Syndrome

Carpal tunnel syndrome is a condition caused by compression of the median nerve at the wrist. There are many causes of such a median nerve compression, both occupational and non-occupational. Carpal tunnel syndrome occurs in the general population and often without any obvious cause.

Increased pressure on the median nerve may be caused by swelling in the carpal tunnel through which the nerve passes resulting from mechanical irritation of adjacent tissues (tendons or muscles). The nerve may be injured due to the increased pressure on it.

Some theories suggest that repetitive stretching or compression of the median nerve in the carpal tunnel results in inflammation of the tissue. This may lead to tissue scarring and a reduction of the size of the carpal canal resulting in compression of the nerve. Ischemia (restriction of blood flow) may also play a role in causing carpal tunnel syndrome. A gradual thickening of the transverse carpal ligament, which may occur spontaneously with aging, has also been suggested as a possible mechanism.

A comparison of medical/scientific research on carpal tunnel syndrome indicates that work activities utilizing the hand/wrist that involve high repetition associated with high force, prolonged flexed postures of the wrist, high repetition associated with cold temperatures, or the use of hand-held vibrating tools are more likely to be associated with increased risk for carpal tunnel syndrome.

Non-work-related risk factors include diseases or conditions which may contribute to reducing the size of the carpal canal including diabetes mellitus, rheumatoid arthritis, thyroid disorders, gout, ganglion formation, and other non-rheumatic inflammatory diseases. Pregnancy and use of oral contraceptives are associated with increased risk for carpal tunnel syndrome. Other factors for which there is some evidence, at times conflicting, include hysterectomy, excision of both ovaries, age at menopause, obesity, and estrogen imbalances. The size of the carpal canal may be reduced by a Colles' fracture (which may or may not have occurred in the course of employment activities). The existence of such non-work-related factors does not reduce the importance of the nature of the employment activities. See #27.40.

The Board recognizes that where the worker was occupationally performing frequent, repetitive and forceful movements of the hand/wrist, including gripping, (particularly if unaccustomed) that are reasonably capable of stressing the tissues of the hand/arm affected by carpal tunnel syndrome, and in the absence of evidence suggesting a non-occupational cause for the worker's condition, a strong likelihood of work causation will exist. These factors are not preconditions to the acceptance of a claim for carpal tunnel syndrome nor are they the only factors which may be relevant.

Consideration should be given to whether the condition is bilateral (involving both wrists) and whether both became symptomatic at the same or different times, in light of the degree to which each hand/wrist is utilized in carrying out the employment activities. As both hands may not perform identical activities and are therefore subject to different risk factors, a work-related carpal tunnel syndrome may be more likely to be unilateral. Carpal tunnel syndrome due to systemic illness is more likely to be bilateral. Consideration should also be given to whether the symptoms of carpal tunnel syndrome improve with rest (stopping work) or whether they continue to progress or worsen. The latter may suggest a non-occupational cause.

Each claim must be determined according to its own merits. If the evidence in a particular claim indicates that there are factors suggesting both an occupational and non-occupational cause for the carpal tunnel syndrome, the decision on the claim can only be a judgment one makes in the particular circumstances by weighing the evidence for and against an employment relationship. Section 99 of the Act will apply if the possibilities for which there is evidential support are evenly balanced.

#27.33 Other Peripheral Nerve Entrapments and Stenosing Tenovaginitis

Cubital tunnel syndrome (an ulnar nerve compression at the elbow), radial tunnel syndrome (a radial nerve compression at the proximal forearm level laterally) and thoracic outlet syndrome (a neurovascular compression of the brachial plexus at the thoracic outlet/axillary region) are syndromes which typically result in numbness and tingling, pain, and weakness of the upper limb(s). They may be caused or aggravated by occupational or non-occupational activities, particularly in an individual who by virtue of their specific anatomical makeup is susceptible to these disorders.

Stenosing tenovaginitis (or tenovaginitis stenosans) is characterized by a fibrous thickening of the tendon sheath which results in a snapping movement of a finger due to swelling and restricted gliding of the tendon. It is often called “trigger finger”. This condition most commonly involves the flexor tendons of the hand.

Medical research does not clearly relate any of these peripheral nerve entrapments or stenosing tenovaginitis to any particular employments and accordingly each claim must be determined according to its own merits.

#27.34 Disablement from Vibrations

A disablement caused by vibrations may be classified either as an injury or a disease, depending on the circumstances. The distinction is dealt with in more detail in #13.10 and #13.12.

#27.35 Unspecified or Multiple-Tissue Disorders

A worker may suffer from a disorder which is not categorized as any of the clinical entities described in #27.11 through #27.34. He or she may suffer from an unspecified symptom complex, perhaps affecting multiple body regions. The attending physician(s) may state that the worker suffers from “repetitive strain injury”, “cumulative trauma disorder”, “overuse syndrome”, “occupational cerviobrachial syndrome”, or the like, due to the not easily categorized clinical findings. The worker and/or the attending physician may believe that the resulting disability is caused or aggravated by employment activities, even though no event or trauma, or series of events or traumas occurred.

Such a claim must be considered on its own merits. Such consideration takes place even though a clinical entity familiar to the Board has not been diagnosed. The matters referred to in #26.04 (recognition by order dealing with a specific case) would apply to such a claim. The Adjudicator should, however, make whatever inquiries they consider appropriate in the circumstances of the claim to determine whether the worker in fact suffers from one or more of the disorders referred to in #27.11 through #27.34, particularly if the worker's attending physician has diagnosed the disorder using one of the broad collective terms such as "repetitive strain injury".

#27.40 Risk Factors

Determining whether the worker's disorder is due to the nature of any employment in which the worker was employed for any of the disorders referred to in #27.11 through #27.35 requires an analysis of risk factors relevant to the causation of ASTDs. As used here a "risk factor" is a general term for a factor which the medical/scientific research indicates may be relevant to the issue of causation. The presence or absence of some risk factors will suggest occupational causation while the presence or absence of others will suggest non-occupational causation. The decision on any individual claim can only be a judgment one makes by weighing the evidence for and against work-relatedness.

A particular risk factor may be physical/mechanical (such as vibration), or physiological (such as flexion of a joint). Risk factors may act directly in causing an ASTD or they may act indirectly by creating the conditions that may lead to an ASTD. Risk factors are not equal nor can they be consistently ranked in order of importance. Their relative importance will vary with the circumstances of each claim. Individual judgment must be exercised in each case to determine the weight to be given to each risk factor having regard to the available evidence.

For most risk factors, the decision-maker will want to consider each of the following in terms of assessing the potential for that risk factor to cause or contribute to the development of a particular ASTD:

- the *location* of the anatomical structure affected (e.g. the elbow):

  The decision-maker should determine what physical motions or activities are performed while carrying out the work duties. Determining what muscle groups, tendons and joints are involved will assist the decision-maker in evaluating whether there is a plausible connection between the work and the disorder. For example, the work may involve repeated gripping of an object, lifting it, rotating it, and placing it down again, such as may be done on a quality control

assembly line. As this work involves frequent supination of the forearm with repetitive movement of the supinators and the tendon attachment to the lateral epicondyle, there is a plausible physiological connection between such work and the development of lateral epicondylitis.

- the *magnitude/intensity* of the risk factor:

  This relates to the amount of musculoskeletal load on the body tissues involved or the amount of physical effort the individual has to put into a particular movement or activity. See discussion on force. For example, the magnitude of the effort to tighten a screw with a screwdriver is much higher than that of turning the page of a book, although the same muscle groups are used.

- the *time variation* of the risk factor (frequency):

  This relates to the amount of time it takes to perform a particular action/activity (the work cycle) and to the amount of time the affected muscle/tendon groups have to return to a neutral recovery state. One way of looking at this is the ratio of time the affected tissues are loaded versus unloaded. For example, the time variation is greater for an assembly line worker who must tighten a screw to a plate once every 10 minutes than it is for such a worker who does the same task 15 times per minute. For the latter worker, the muscle/tendon groups have little or no time to return to a neutral resting state.

- the *duration* of the risk factor:

  This relates to the length of time a person is exposed to a particular task. For example, a person may be exposed to a task that continually uses the same muscle/tendon groups hour after hour, day after day, etc.

The following represents a non-exhaustive list of risk factors relevant to the adjudication of claims for the conditions referred to in #27.11 through #27.35:

Related to the performance of the work

repetition:

- the cyclical use of the same body tissues either as a repeated motion or as repeated muscular effort without movement. The shorter the time variation of a repeated muscle, tendon, or joint movement required to perform a task the less time such tissues will have to return to the resting state for recovery, and the higher the potential for causing an ASTD. The time variation of repetition may be expressed as the frequency of the work cycle.

force:

- the musculoskeletal load on the tissues involved. This load may be manifested on the body through tension (such as muscle tension), pressure (such as increased pressure in the carpal canal), friction (such as between a tendon and its surrounding sheath), or irritation (such as irritation of a peripheral nerve). The greater the magnitude/intensity of the force required by the muscle/tendon group involved, the greater the potential for causing an ASTD and the shorter its latency.

static load:

- when a limb is held or maintained against gravity, or against some other external force. Static loading can also be considered to be present when, upon moving a limb, the musculoskeletal load does not return to zero after each motion. As there are limitations to the body's ability to deal with such sustained loads, the duration and time variation elements become important, as well as task invariability.

task variability:

- the degree to which the task remains unchanged thus causing loading of the same tissues in the same way, particularly if there is no change or interruption in a repeated task. The less varied the task, the less likely are the affected tissues able to return to a resting state for recovery.

awkward postures:

- postures such as where joints are held at or near the end range of motion for that joint, or where loads are supported by passive tissues, or where muscle tension is required to hold the posture (such as

holding the arm straight out at shoulder height). Awkward postures place significant stresses on tendons, muscles and other soft tissues and reduce the tolerances of such tissues. Some postures may adversely affect the physiologic function of the arm as a result of impingements, occlusion of blood flow and the like. Postures to watch for include:

- overhead reaching and lifting
- postures involving static shoulder loads
- sustained shoulder abduction or flexion
- sustained flexion or extension of the wrist
- sustained ulnar deviation of the wrist

local mechanical stresses:

- result from physical contact between body tissues and objects in the work environment such as tools, machinery, and products. This usually involves the knee, shoulder, elbow, wrist and hand. Point pressure may also occur at the sides of fingers where the digital nerves and blood supply are located and may compromise the normal physiological functioning of these body structures.

shock (impact loading):

- may result from kickback or torque resistance such as may occur when using impact wrenches or nut drivers. Shock may also occur if the worker uses a limb as a hammer such as may occur if they are trying to strike something into place.

grip type:

- pinch type grips require about five times higher tendon and muscle loads than a power grip which utilizes the entire hand to grasp an object.

vibration:

- may consist of hand/arm vibration (perhaps secondary to the use of hand-held, vibrating tools) or whole-body vibration (perhaps secondary to sitting in a piece of machinery that vibrates). The greater the duration and/or intensity of the vibration, the higher is the potential for causing an ASTD.

extremes of temperature:

- hot or cold. Cold may have direct damaging affects on the tissue through vascular constriction and other mechanisms or may induce the worker to wear protective clothing, such as gloves, which may in turn impact tissue loading and grip mechanisms.

unaccustomed activity:

- new job task or machine; return to work after a leave or other absence. Resistance to injury is considered to be lower for unaccustomed activity due to a lack of acclimatization/adaptation. The general fitness level of the person may have an impact on this factor
-

Related to the work environment

ergonomic aspects:

- includes poorly designed workstations, poorly designed task methods, and poor tool design. Is the work performed in an ergonomically proper manner? Poor ergonomics may result in, among others, prolonged static loading, awkward postures, local mechanical stresses, and non-optimal work techniques.

work organization:

- the way in which the work tasks are structured, supervised, and processed. The way in which work tasks are organized will affect the way in which the work is performed, and the degree to which affected tissues may be utilized. For example, if overtime is a regular part of the employment, there will be periods of additional loading of muscle/tendon groups. If worker remuneration involves the payment of production incentives (such as piece work), some workers may attempt a faster pace or may take less rest periods. A lack of supervision may result in workers adopting non-approved work techniques.

work behaviour:

- refers to worker behavior such as adopting non-optimal techniques or work habits. Is there worker preference for improper methods?
  cognitive demands:

- the amount of mental effort required to perform the work tasks. Cognitive demands can impact the level of muscular tension which may result in muscle overload.

rest breaks/rotation:

- distribution of rest breaks and frequency of job rotation impact the effect of other risk factors; the more rest breaks the greater is the opportunity for tissues to return to a neutral state for recovery; the more the task rotation the lower is the loading of particular muscle/tendon groups.

Related to the individual

age:

- the normal reparative and wound-healing process slows with increased age.

moderate to heavy smoking:

- nicotine may reduce blood flow to the tissues.

previous similar history:

- a history of prior musculoskeletal disorder; previous injury.

inflammatory disorders:

- rheumatoid arthritis, ankylosing spondylitis, systemic sclerosis, polymyositis, colitis and other non-rheumatic inflammatory diseases may result in inflammatory symptoms of the musculoskeletal system.

diabetes mellitus:

- places an individual at greater risk for peripheral neuropathies such as carpal tunnel syndrome.

Medical/scientific literature suggests that ASTDs occur when through the interaction of a number of factors, with the contribution of individual characteristics (coping mechanisms, genetic tendencies, underlying disease processes), the capacity of the person to tolerate or to adapt to the demands being made are exceeded. The risk of this occurring increases where the tissues affected have less opportunity to return to a resting state where recovery and perhaps adaptation occurs.

In assessing the likelihood that the worker's employment activities have played a significant role in causing or aggravating the diagnosed ASTD, the principal risk factors to consider when looking at the work performed are the intensity, duration and frequency (time variation) of:

- repetition
- force,
- posture, and
- vibration

Other risk factors may have more or less significance depending on the circumstances of the claim.

The absence of significant force is not reason in itself to automatically conclude the work activities are unlikely to have caused or aggravated the ASTD. It is simply one relevant factor. The intensity, duration and frequency of the repetition, perhaps combined with the posture, may be sufficient to cause one to conclude the work played a significant causative role.

The risk factors related to the individual will be more or less important depending on the *intensity, duration* and *frequency* of the risk factors related to the performance of the work. Where these latter risk factors cause the decision-maker to conclude that the work creates a relatively high potential for causing or aggravating the ASTD, the risk factors related to the individual may be considered to be less important. On the other hand, they may be considered more important where the risk factors related to the performance of the work cause the decision-maker to conclude that the work does not create such a high potential for causing or aggravating the ASTD. Risk factors related to the individual may be responsible for causing or aggravating the ASTD. They may also, however, render a worker more susceptible where shorter or less intense workplace exposures may cause an ASTD or activate or aggravate a pre-existing disease.

The importance and effect of particular factors in the circumstances of any individual claim is a matter of individual judgment exercised having regard to the medical and other evidence available.

#28.00 CONTAGIOUS DISEASES

There are a number of contagious diseases recognized by the Board as occupational diseases either in Schedule B or by regulation. See #26.03.

A worker is not entitled to compensation simply because he or she contracted the disease while at work. For the disability to be compensable, there must be something in the nature of the employment which had causative significance.

Thus, in these cases of contracting a contagious disease at work, it is a requirement for compensation that either:

1. The nature of the employment created for the worker a risk of contracting a kind of disease to which the public at large is not normally exposed; or

2. The nature of the employment created for the worker a risk of contracting the disease significantly greater than the ordinary exposure risk of the public at large. In this category, it would not be sufficient to show only that the worker meets more people than workers in other occupations, but it would be significant to show that in the particular employment the worker meets a much larger proportion of people with the particular disease than is found in the population at large.

It may help to illustrate these principles:

Example 1 — Suppose an outbreak of meningitis is affecting the community at large. The disease may be spreading at places of work, in the home, at schools, at churches, at social events, at sporting events, and every place where people meet. The Board would not, with regard to each worker suffering from the disease, seek evidence to decide whether that worker contracted the disease at work or elsewhere. The disease would be viewed as a public health problem, not a disease due to the nature of any particular employment, and compensation for the workers involved must be found under general systems relating to sickness benefits, not under workers' compensation.

Example 2 — Suppose there are three cases of meningitis reported in the community. Victim 1 is a tourist from abroad. Victim 2 is a nurse who was engaged in the treatment of Victim 1. Victim 3 is a nurse who was working closely with Victim 2. Here the employment involved a risk of contracting a disease of a kind to which the public at large are not exposed, and the contracting of the disease by Victims 2 and 3 was due to the nature of their employment.

Example 3 — Suppose the disease is one of a low order of contagiousness, and one that does not normally spread through the public at large, but which can be contagious when there is exceptionally close contact, such as may come from two workers constantly holding materials together, or sharing the same room. If, in this situation, a worker catches the disease from a fellow worker, from the employer, or from a client of the employer, with whom the worker has been placed in exceptionally close proximity, it may well be concluded that the disease is due to the nature of the employment. For example, where two

workers share sleeping quarters on board a ship, and one contracts tuberculosis from the other, the worker who contracted tuberculosis from the shipmate may be compensated.

Example 4 — Suppose a courier develops mononucleosis and claims compensation on the ground that in the job he or she meets more people than workers in most occupations and therefore has a greater risk of exposure to contagious diseases. Such a claim would not be allowed. The disease is one that spreads in the population at large, and claims of this nature cannot be allowed or denied by estimating the extent to which each employment involves mixing with the public.

Example 5 — Suppose a maintenance mechanic from British Columbia is sent to repair machinery in use by a customer overseas. While there, the worker contracts a disease that is commonly found among the population at large in that country, but which is not a common disease in British Columbia. That would be compensable. The nature of the employment has exposed the worker to a disease of a kind to which the people of this province are not normally exposed.

There is no requirement that a worker with a contagious disease should name a contact, but there should be some evidence of a contact. For example, if the worker was employed in a hospital, and there were three patients known to be in his or her working area of the hospital suffering from the disease, an inference may be drawn from the circumstantial evidence that the worker contacted the disease there, even though they may not remember the names of the patients, or may not remember whether they actually had contact with them. The strength of this circumstantial evidence would obviously depend partly on the strength of evidence relating to alternative possibilities, such as whether the disease is extremely rare or one that is common in the community elsewhere. In other words, where there is no solid evidence of actual contact, the Adjudicator must still weigh the possibilities on the circumstantial evidence of possible contact and not simply reject the claim without weighing the possibilities.

#28.10 Scabies

Claims for scabies will be accepted if the following three conditions are met:

1. The worker is employed in a hospital, nursing home, or other institution where there is a recognized hazard of contracting an infectious disease, or is directly involved in transporting patients or residents to or from such facilities.

2. There is satisfactory evidence the worker has had contact with an infected patient, resident or co-worker at the place of employment and the condition has occurred within a reasonable period of time following

such contact (measured against the known incubation period for scabies). Evidence that there were persons in the place of employment known to be suffering from scabies is sufficient for this purpose if the worker would normally have direct contact with such persons in the performance of his or her employment duties.

3. The diagnosis of scabies is confirmed by a staff occupational health nurse, or by a physician or other qualified practitioner, and is not simply speculative. Skin scrapings need not be taken in order to give a positive diagnosis of scabies.

If any of the three conditions have not been met, there is likely to be insufficient positive evidence to conclude that the worker suffers from scabies which is due to the nature of his or her employment.

#29.00 RESPIRATORY DISEASES

#29.10 Acute Respiratory Reactions to Substances with Irritating or Inflammatory Properties

Schedule B lists "Acute upper respiratory inflammation, acute pharyngitis, acute laryngitis, acute tracheitis, acute bronchitis, acute pneumonitis, or acute pulmonary edema (excluding any allergic reaction, reaction to environmental tobacco smoke, or effect of an infection)" as an occupational disease. The process or industry listed opposite to it is "Where there is exposure to a high concentration of fumes, vapours, gases, mists, or dust of substances that have irritating or inflammatory properties, and the respiratory symptoms occur within 48 hours of the exposure, or within 72 hours where there is exposure to nitrogen dioxide or phosgene".

There are many agents used in industry and commerce in the province which have irritating or inflammatory properties, and which in sufficient concentrations can produce respiratory symptoms if inhaled. Symptoms associated with the inhalation of such substances can vary from mild transient symptoms (such as a mild burning sensation affecting the eyes, nose and throat) to significant symptoms throughout the respiratory tract (such as dyspnea and respiratory distress). Significant exposure to some substances may result in persistent respiratory symptoms.

Onset of symptoms can occur within a few minutes or several hours of the exposure, depending on the substance. For the presumption in Section 6(3) of the Act to apply, the symptoms must appear within 48 hours of the exposure, unless the exposure is to nitrogen dioxide or phosgene, in which case the onset of symptoms must occur within 72 hours.

A claim for compensation made by a worker who has developed persistent or chronic respiratory symptoms considered to be due to exposure to a substance with irritating or inflammatory properties, must be considered on its own individual merits without the benefit of a presumption in favour of work causation (unless the claim meets the requirements of one of the other items of Schedule B). This includes claims for chronic bronchitis, emphysema, chronic obstructive pulmonary disease, obliterative bronchiolitis, reactive airways dysfunction syndrome (RADS), chronic rhinitis, and conditions considered to be due to exposure to tobacco smoke. The same is true of a claim made by a worker with acute respiratory symptoms where the requirements of Section 6(3) of the Act are not met (see #26.22). Where a worker who develops an acute reaction to a substance with irritating or inflammatory properties subsequently develops a persistent or chronic respiratory condition, a decision will be made based on the merits and justice of that claim on whether the chronic condition is a compensable consequence of the acute reaction.

A claim made by a worker who has inhaled a vapour or gas which was at a emperature high enough to cause thermal injury (such as inhaling steam) will be treated as a claim for a personal injury and will be adjudicated in accordance with the policies set out in Chapter 3.

Use of the words “high concentration” in Schedule B is a recognition that the amount of the particular substance in the air must be significant for the presumption to apply. The manner in which an exposed individual will react will depend on the properties of the substance inhaled (e.g., acidity/alkalinity, chemical reactivity, water solubility, asphyxiating potential) and the amount inhaled. Individual judgment must be exercised in each case to determine whether there was a "high concentration" of the particular substance having regard to the medical and scientific evidence available, including evidence as to the irritating and/or inflammatory properties of that substance.

#29.20 Asthma

Schedule B lists “Asthma” as an occupational disease. The process or industry listed opposite to it is “Where there is exposure to

(1) western red cedar dust; or
(2) isocyanate vapours or gases; or
(3) the dust, fume of vapours of other chemicals or organic material known to cause asthma.”

There are many substances which are either known to cause asthma in a previously healthy individual or of aggravating or activating an asthmatic reaction in an individual with a pre-existing asthma condition. The significance

of occupational exposures to these substances may be complicated by evidence that the worker is exposed to such substances in both occupational and non-occupational settings. In the investigation of the claim, the Adjudicator should seek evidence of whether the worker is exposed to any sensitizing substances (obtaining where available any material safety data sheets), on the nature and extent of occupational and non-occupational exposure to such substances, and on whether there is any correlation between apparent changes in airflow obstruction/responsiveness and exposure to such substances. Additional medical evidence may be available in the form of airflow monitoring, expiratory spirometry, inhalation challenge tests, and skin testing for sensitization.

A pre-existing asthma condition is not compensable unless such underlying condition has been significantly aggravated, activated, or accelerated by an occupational exposure. A worker is not entitled to compensation where his or her pre-existing asthma condition is triggered or aggravated by substances which are present in both occupational and non-occupational settings unless the workplace exposure can be shown to have been a significant cause of an aggravation of the condition. A speculative possibility that a workplace exposure to such a substance has caused an aggravation of the pre-existing asthma is insufficient for the acceptance of a claim.

Compensation is not payable because a worker develops an allergy or sensitivity to a substance or substances as a result of their employment. Compensation may be paid where a workplace exposure to the allergen or substance results in an asthmatic reaction.

In the case of a compensable asthma or a reaction of the respiratory tract to a substance with irritating or inflammatory properties, temporary disability benefits are payable until the temporary disability ends or until the worker's symptoms become stabilized. Where the worker's symptoms do not entirely resolve and he or she is left with a permanent impairment of the respiratory system, a disability award may be granted. However, no such award can be made when the worker's symptoms have resolved and they are simply left with the underlying allergy or sensitivity. Not only is the worker not now suffering from the occupational disease set out in Schedule B, but they are not disabled from working. The Board cannot grant a permanent disability award to a person who has the same physical capabilities as they had previous to the occurrence of the occupational disease, but who is precluded from a limited number of occupations because of a remaining allergy or sensitivity. No permanent disability award can be made to a worker with a pre-existing condition when they have returned to their pre-exposure state.

Where a worker who is allergic to western red cedar dust declines to take any employment which involves exposure to that dust, such worker is taking a preventive measure. Compensation is not payable for such preventive measures. However, rehabilitation assistance may be provided to a worker in this situation (see #86.30).

#29.30 Bronchitis and Emphysema

Bronchitis and emphysema are recognized as occupational diseases by regulation under Section 1 of the Act.

Bronchitis and emphysema were recognized by regulation as occupational diseases on July 11, 1975. Medical evidence indicates that it would be an extremely rare case where a worker's employment environment could be shown to be the cause of the bronchitis or emphysema.

Where a person claims compensation in respect of bronchitis or emphysema, the Board considers that a history of heavy or significant cigarette smoking raises a strong inference that the worker's condition is due to the smoking and not to the nature of the employment. Against this inference must be weighed any evidence which supports the claim, but the inference will not be rebutted where the opposing evidence is weak or conflicting.

The principles set out above do not mean that a worker who has never smoked cigarettes or has smoked an insignificant amount will automatically be compensated for any bronchitis and emphysema. Evidence will still have to be produced that the disease is due to the nature of the employment. The advantage such a worker will have is that a major non-occupational cause of these diseases will have been eliminated. (7)

#29.40 Pneumoconioses and Other Specified Diseases of the Lungs

The guiding legislation in compensation for pneumoconioses is provided in Sections 6(3) and 6(7) through 6(11) of the *Workers Compensation Act*. Pneumoconiosis is a general medical term used to describe certain lung diseases due to deposition of particulate matter in the lungs.

#29.41 Silicosis

Schedule B lists "Silicosis" as an occupational disease. The process or industry described opposite to it is "Where there is exposure to airborne silica dust including metalliferous mining and coal mining". This later description does not exclude the presumption from applying to workers exposed to airborne silica dust engaged in employments other than metalliferous mining and coal mining.

By virtue of Section 6(8) of the Act, a worker in the metalliferous mining industry or coal mining industry who becomes disabled from uncomplicated silicosis or from silicosis complicated with tuberculosis is entitled to compensation for total or partial disability. Where death results from the disability, the dependants of the worker are entitled to compensation. However, neither a worker nor a

dependant is entitled to compensation for the disability or death unless the worker:

(a) has been a resident of the province for a period of at least three years last preceding his or her disablement, or unless at least two-thirds of their exposure to dust containing silica was in this province; and

(b) was free from silicosis and tuberculosis before being first exposed to dust containing silica in the metalliferous mining or coal mining industry in this province; and

(c) has been a worker exposed to dust containing silica in the metalliferous mining or coal mining industry in the province for a period or periods aggregating three years preceding his or her disablement, or for a lesser period if the worker was not exposed to dust containing silica anywhere except in this province.

"Silicosis" is defined in Section 6(7) as ". . . a fibrotic condition of the lungs caused by the inhalation of silica dust". "Metalliferous mining industry" is defined in Section 1 to include "the operations of milling and concentrating, but does not include any other operation for the reduction of minerals".

#29.42 Meaning of Disabled from Silicosis

The restrictions contained in Section 6(1) do not apply to silicosis. It is, therefore, not a requirement of a claim for silicosis that there should be a lessened capacity for work, or that the worker should be disabled from earning full wages at the work at which he or she was employed.
It is a requirement in a claim for silicosis that the worker be "disabled" from the silicosis, or from silicosis complicated with tuberculosis. There is no definition of "disability" in the Act, and the Board has not attempted any comprehensive definition. If a worker has a condition of an internal organ which is so slight as to be unnoticeable to that person, and which causes no significant discomfort or other ill effects, that is not a "disability".

It can be difficult to fix the date for commencing the pension when there is no change of jobs or reduction in earnings to mark the inception of the disability. No general rules can be laid down for this purpose. The Adjudicator must decide the question according to the available evidence. However, if the evidence does not clearly establish when the disability commenced, and there is no evidence of the existence of a disability prior to the receipt of a particular medical report, the Adjudicator may properly decide that, according to the available evidence, the disability commenced on the date of the medical examination which was the subject of that report.

There may also be a difficulty in fixing the worker's average earnings when such worker is not employed at the time when the disability commenced. The Adjudicator should generally refer back to the employment or employments in which the worker was most recently engaged and base any pension on the previous earnings thus discovered.

#29.43 Exposure to Silica Dust Occurring Outside the Province

Where the three criteria set out in #29.41 are met, there will be no reduction in benefits according to the proportion of exposure to silica dust occurring outside the province versus that within. The Board will therefore pay full compensation to the worker without regard to the extent of exposure to silica dust outside the province. (8)

#29.45 Pneumoconiosis

When a worker has sustained pulmonary injury by a disabling form of pneumoconiosis as a result of exposure to dust conditions that are deemed by the Board to have contributed to the development of the disease in employment in the province in an industry in which that disease is an occupational disease under the Act, such worker or their dependants is or are entitled to compensation only if the worker was free from pneumoconiosis and tuberculosis before being first exposed to those dust conditions in the province, and if the worker's residence and exposure to the dust conditions have been of the duration required to entitle a worker to compensation for silicosis under #29.41. (9)

Schedule B lists "Other pneumoconioses" as an occupational disease. The process or industry described opposite to it is "Where there is exposure to the airborne dusts of coal, beryllium, tungsten carbide, aluminum or other dusts known to produce fibrosis of the lungs".

#29.46 Asbestosis

Schedule B lists "Asbestosis" as an occupational disease. The process or industry described opposite to it is "Where there is exposure to airborne asbestos dust".

A worker need not necessarily have worked directly with asbestos for the presumption to apply. The exposure may be a secondary exposure, such as working in an area where asbestos was used as insulation which was for years in a friable or decayed condition.

#29.47 Diffuse Pleural Thickening or Fibrosis and Benign Pleural Effusion

Schedule B lists "Diffuse pleural thickening or fibrosis, whether unilateral or bilateral" as an occupational disease. The process or industry described

opposite to it is "Where there is exposure to airborne asbestos dust and the claimant has not previously suffered and is not currently suffering collagen disease, chronic uremia, drug-induced fibrosis, tuberculosis or other infection, trauma, or disease capable of causing pleural thickening or fibrosis."

Schedule B also lists "Benign pleural effusion, whether unilateral or bilateral" as an occupational disease. The process or industry described opposite to it is "Where there is exposure to airborne asbestos dust and the claimant has not previously suffered and is not currently suffering collagen disease, chronic uremia, tuberculosis or other infection, trauma, or disease capable of causing pleural effusion."

These items in Schedule B recognize that diffuse pleural thickening or fibrosis whether unilateral or bilateral, and benign pleural effusion, whether unilateral or bilateral, are likely to be due to the nature of the employment of workers exposed to airborne asbestos dust where the other known causes of the disease can be excluded.

#29.48 Mesothelioma

Schedule B lists "Mesothelioma (pleural or peritoneal)" as an occupational disease. The process or industry described opposite to it is "Where there is exposure to airborne asbestos dust." Mesothelioma is a malignancy arising from the mesothelial tissue. As with Asbestosis, the exposure to airborne asbestos dust may be a secondary exposure.

#29.50 Presumption Where Death Results from Ailment or Impairment of Lungs or Heart

Section 6(11) provides that:

> "Where a deceased worker was, at the date of his death, under the age of 70 years and suffering from an occupational disease of a type that impairs the capacity of function of the lungs, and where the death was caused by some ailment or impairment of the lungs or heart of non-traumatic origin, it must be conclusively presumed that the death resulted from the occupational disease."

This provision does not apply to deaths occurring before July 1, 1974.

The question whether the deceased suffered from an ". . . occupational disease of a type that impairs the capacity of function of the lungs, . . ." is not determined by the failure or success of any claim made in the deceased's lifetime. Thus, the Board can decide that there was such a disease at the date of death, even though it disallowed a claim made by the worker in respect of that disease. Alternatively, it can now conclude that there is no such disease, notwithstanding it accepted a claim made by the worker before his or her death

in respect of the same condition. This can well happen because often there is new evidence available following a death, typically in the form of an autopsy report which may be the best evidence available.

Once the age of the worker and the conditions set out in Section 6(11) have been established, it is conclusively presumed that the death resulted from the occupational disease. This presumption cannot be rebutted by contrary evidence.

If the deceased worker was over 70 years of age or for some other reason the presumption cannot be applied, medical and other evidence must be examined to determine whether the death resulted from the occupational disease

#30.00 CANCERS

Mesothelioma is covered in #29.48.

#30.10 Bladder Cancer

Schedule B lists "Primary cancer of the epithelial lining of the urinary bladder, ureter or renal pelvis" as an occupational disease. The process or industry described opposite to it is "Where there is prolonged exposure to beta-naphthylamine, benzidine, or 4-nitrodiphenyl". In adjudicating a claim for bladder cancer it is incumbent on the Board officer to assess whether the worker has had prolonged exposure to any of the substances listed in Item 4(h) of Schedule B.

In addition to the chemicals listed in Schedule B, the Board recognizes that aluminum smelter workers exposed to coal tar pitch volatiles have an increased incidence of bladder cancer.

Claims for bladder cancer from aluminum smelter workers which do not meet the descriptions contained in Schedule B are adjudicated on the basis of cumulative (or total) exposure to benzo-a-pyrene, a constituent of coal tar pitch volatiles. In the adjudication of such a claim the following principles and procedures apply:

1. If the disease develops within 10 years of a worker's first exposure to benzo-a-pyrene, it will not normally be considered to have resulted from that exposure.

2. In determining the severity of a worker's exposure, regard will, where the information is available, be given to the following ranking of exposure:

Ranking of Exposure	Exposure to B.S.M. (mg/m^3)
Zero	0
Low	0.1
Medium	0.6
High	1.5

B.S.M. refers to benzene soluble materials.

3. To determine a worker's total occupational exposure, the years which the worker has spent in each job will be multiplied by the concentration of B.S.M. determined for that job by the rankings referred to above. For example, five years in a high risk job will produce a total exposure to B.S.M. of 7.5 mg/m^3 years (5 multiplied by 1.5). The worker's total or cumulative exposure to benzene-soluble materials is the sum of the exposures calculated for each job.

   Any exposure which occurred in the 10 years immediately preceding the date the bladder cancer was first diagnosed shall be excluded from this calculation.

4. To convert benzene-soluble materials exposure to benzo-a-pyrene exposure, the worker's total exposure to benzene-soluble materials (expressed in milligrams per cubic metre years or mg/m^3 years) is multiplied by 11.0. The result (total or cumulative benzo-a-pyrene exposure) is expressed in micrograms per cubic metre years or $\mu g/m^3$ years.

5. The worker's relative risk of having developed bladder cancer as a result of his/her employment in the aluminum smelter is then determined by comparing the worker's cumulative exposure to benzo-a-pyrene (calculated in accordance with the above principles) with the relative risk figures contained in the following table:

Cumulative Exposure to Benzo-a-pyrene	Relative Risk
0	1.00
5	1.16
10	1.32
15	1.48
20	1.64
25	1.80
30	1.96
31.25	2.00
35	2.12
40	2.28

45	2.44
50	2.60
60	2.92
70	3.24
80	3.56
90	3.88

Note: These numbers take into account scientific uncertainty and are based on the upper 95% confidence limit of the exposure-response relationship.

Where the worker's corresponding relative risk is equal to 2.00 or greater, it will be considered that the bladder cancer resulted from such employment and the claim will be accepted.

6. Where, having applied the above principles, the worker's relative risk is less than 2.00, or where the information necessary to calculate the worker's relative risk is not available, a detailed investigation will be carried out by the Board Officer into the worker's job history to determine whether the level of exposure assessed for that worker is reasonable. Relevant considerations may include special work assignments, hours of overtime, individual work practices, and any other characteristics of the workplace or work environment which may have had an impact on the duration and intensity of the exposure. If, following this investigation, it is concluded that the worker's relative risk is less than 2.00, it will be considered that the bladder cancer is not due to the worker's employment in the aluminum smelter and the claim will be disallowed.

7. Where the employer and the worker, through the worker's union, reach an agreement as to the total exposure of the worker to benzene-soluble materials in mg/m^3 years or to benzo-a-pyrene in $\mu g/m^3$ years, the Board is not bound to accept this amount and may follow the investigation and determination procedures outlined above. The amount agreed by the employer and the union may, however, be accepted in lieu of the investigation and determination procedures set out above if the agreed amount appears reasonable in the known circumstances of the case.

8. Smoking is a strong non-occupational risk factor for bladder cancer. Smoking and exposure to benzo-a-pyrene act synergistically in increasing the risk of developing bladder cancer. If the worker's relative risk calculated in accordance with the above principles is 2.00 or greater, the worker's smoking history will not change the conclusion that the bladder cancer was due to the employment.

#30.20 Gastro-intestinal Cancer

Schedule B lists "Gastro-intestinal cancer (including all primary cancers associated with the oesophagus, stomach, small bowel, colon and rectum excluding the anus, and without regard to the site of the cancer in the gastro-intestinal tract or the histological structure of the cancer)" as an occupational disease.

The process or industry described opposite to Gastro-intestinal cancer is "Where there is exposure to asbestos dust if during the period between the first exposure to asbestos dust and the diagnosis of gastro-intestinal cancer there has been a period of, or periods adding up to, 20 years of continuous exposure to asbestos dust and such exposure represents or is a manifestation of the major component of the occupational activity in which it occurred."

Gastro-intestinal cancer suffered by a worker who has not been exposed to asbestos fibres in the course of their employment, or whose exposure to such fibres does not substantially have the duration, continuity and extent described in the second column of Schedule B, will not normally be considered to be due to employment.

Where there has been less than 20 years of continuous exposure to asbestos fibres, such that the presumption in Section 6(3) does not apply, but there has been substantial compliance with the requirements of the second column of Schedule B, the Adjudicator will consider whether the evidence indicates that the gastro-intestinal cancer is due to the nature of the worker's employment. Whether or not the compliance is substantial is a matter of judgment for the Adjudicator. The greater the gap between the worker's period of exposure and the 20-year period, the less likely is the compliance to be substantial and the less likely is the disease to be due to the nature of the employment. (10)

#30.50 Contact Dermatitis

Schedule B lists "Contact dermatitis" as an occupational disease. The process or industry described opposite to it is "Where there is excessive exposure to irritants, allergens or sensitizers ordinarily causative of dermatitis".

The payment of temporary disability benefits and permanent disability pensions are subject to the same general principles as are set out in #29.20 in respect of asthma or a reaction of the respiratory tract to a substance with irritating or inflammatory properties. Therefore, there is no disability for the purpose of the *Workers Compensation Act* unless the worker has an actual loss of body function or physical impairment resulting from the dermatitis which causes the worker to be disabled from earning full wages at the work at which he or she was employed.

Temporary disability benefits are payable while the disability is a temporary one, but cease when it disappears or stabilizes or becomes permanent. If the worker's symptoms do not entirely resolve and they are left with a permanent impairment, a disability award may be granted. However, neither temporary disability benefits nor a permanent disability pension is payable simply because the worker has developed a susceptibility to react to a certain substance as a result of his or her work which causes periods of temporary impairment if he or she is exposed to the particular substance, but otherwise causes no complaints. Rehabilitation assistance may be provided to assist the worker in obtaining alternative employment which does not expose him or her to the substance in question (see #86.30).

#30.70 Heart Conditions

Heart-related conditions which arise out of and in the course of a person's employment and which are attributed to a specific event or cause or to a series of specific events or causes are generally treated as personal injuries. They are therefore adjudicated in accordance with the policies set out in Chapter 3. If the heart-related condition of a worker is one involving a gradual onset and is not attributed to a specific event or cause or to a series of events or causes, the claim will be adjudicated under Section 6 of the Act. (See #15.10 and #15.15).

#31.00 HEARING LOSS

There are two bases on which compensation can be paid for hearing loss:

(a) If the hearing loss is traumatic and work-related, compensation is paid as with any other injury under Section 5(1) and, if a permanent disability results, a pension is awarded in accordance with the scale provided for in the Permanent Disability Evaluation Schedule (for hearing loss that is secondary to an injury see #22.00).

(b) If the hearing loss has developed gradually over time as a result of exposure to occupational noise, it is treated as an occupational disease. However, the provisions of Section 6 do not apply unless the worker ceased to be exposed to causes of hearing loss prior to September 1, 1975. In all other cases, Section 7 of the Act applies. If the provisions of Section 6 of the Act apply to the claim, the worker may be entitled to the payment of health care in the form of hearing aids even if they were not disabled from earning full wages at the work at which they were employed (see #26.30).

Section 7(1) provides that "Where a worker suffers loss of hearing of non-traumatic origin, but arising out of and in the course of employment . . ., that is a greater loss than the minimum set out in Schedule D, the worker is entitled to compensation . . ." Schedule D is set out in #31.40.

Schedule B lists "Neurosensory hearing loss" as an occupational disease. Medical research indicates that it is only hearing loss of a neurosensory nature which is caused by exposure to noise over time (although this type of hearing loss may also result from other causes unrelated to exposure to noise). As a result, the Board's responsibility is limited to compensating workers for occupationally-induced neurosensory hearing loss. This is further emphasized in Section 7 of the Act which requires that the loss of hearing be of non-traumatic origin and that it arise out of and in the course of employment.

In situations where a hearing loss is partly due to causes other than occupational noise exposure, the total hearing impairment is initially measured using pure tone air conduction pursuant to Schedule D. Having done this, in order to comply with the Act, other measures, such as bone conduction tests, are carried out to assess the portion of the total loss which is neurosensory and the portion which is due to other causes.

Having made this determination, the factual evidence on the claim is then assessed to determine whether all, or only part of, the neurosensory loss is due to occupational exposure to causes of hearing loss in British Columbia as required by the Act. The resulting portion of the worker's total impairment is then assessed for a pension using the percentage ranges listed in Schedule D.

Tinnitus alone is not considered to be a pensionable condition. It is recognized, however, that tinnitus, in combination with a pensionable degree of hearing loss, may have an impact on a worker's employability and affect the amount of the resulting pension.

#31.10 Date of Commencement of Section 7

Section 7(5) of the Act provides as follows:

> "Compensation under this section is not payable in respect of a period prior to September 1, 1975; but future compensation under this section is payable in respect of loss of hearing sustained by exposure to causes of hearing loss in the Province either before or after that date, unless the exposure to causes of hearing loss terminated prior to that date."

Section 7 expressly applies only to hearing loss of non-traumatic origin which can only mean loss of hearing over some period of time as a cumulative effect. Therefore "terminated" as used in Section 7(5) means the end once and for all of a course of exposure to causes of hearing loss. Exposure is not terminated as long as the worker continues to undergo exposure arising out of and in the

course of the worker's employment in British Columbia, no matter how intermittent or how far apart periods of exposure might be. Only retirement or other cessation from employment in industries which expose the worker to causes of hearing loss qualify as "termination". Subsequent exposure for any period of time in bona fide employment allows for consideration of compensation under Section 7.

Only exposure to noise in industries under Part 1 of the Act after September 1, 1975 should be considered to determine whether or not a worker qualifies for compensation under Section 7.

If a worker's exposure to causes of hearing loss terminated prior to September 1, 1975, no compensation is payable under Section 7 whatever may be the reasons for this termination. No exception can be made if, for instance, the termination came about because a previous compensable injury forced the worker to leave his or her employment. A worker whose exposure ceased prior to September 1, 1975 may be entitled to health care (hearing aids) under
Section 6 of the Act.

#31.20 Amount and Duration of Noise Exposure Required by Section 7

A claim is acceptable where, as a minimum, evidence is provided of continuous work exposure for two years or more at eight hours per day at 85 dBA or more, and when other evidence does not disclose any cause of hearing loss not related to work. The Board considers it reasonable to set the 85 dBA minimum standard for compensation purposes and then to allow a restricted measure of discretion for the acceptance of claims where the evidence is abundantly clear that the worker is extraordinarily susceptible and has been affected by exposure to noise at a lesser level.
The *Industrial Health & Safety Regulations* in effect at the time of the enactment of Section 7 set 90 dBA for eight hours of worker exposure as the maximum permissible limit for noise in industry. However, it was recognized from all available information that to retain this standard for claims purposes would result in an inability to accept claims on behalf of approximately 15% of the worker population who are unusually susceptible to ill effects from noise below 90 dBA. As a result the *Industrial Health & Safety Regulations* effective on January 1st, 1978, retained 90 dBA criterion for the employment environment, but the 85 dBA standard was retained for compensation purposes. (11)

The Board does not accept evidence of the wearing of individual hearing protection as a bar to compensation. However, in the case of soundproof booths, where evidence shows that the booth was used regularly, was sealed and was generally effective, it may be difficult to accept that the work environment in question contributed to the hearing loss demonstrated.

Where the exposure to occupational noise in British Columbia is 5% or less of the overall exposure experienced by the worker, the claim is disallowed. Such a minimal degree of exposure is insufficient to warrant a pensionable degree of disability. Where the exposure to occupational noise in British Columbia is 90% or greater of the total exposure, a claim is allowed for the total hearing loss suffered by the worker. For percentages between 5 and 90, the claim is allowed for only that percentage of the hearing loss which is attributable to occupational noise in British Columbia, and the Board will accept responsibility for all health care costs related to the total hearing loss including the provision of hearing aids.

It has been suggested that after 10 years of exposure further loss is negligible. Generally speaking, the evidence is that the first 10 years has a significant effect at higher frequencies. However, where lower frequencies are concerned (up to 2,000 hz.) hearing loss continues after that time and may, in fact, accelerate in those later years. Therefore, since the disability assessment under Schedule D relies on frequencies of 500, 1,000 and 2,000 hz., no adjustments for duration of exposure are made.

#31.30 Application for Compensation under Section 7

Section 7(6) provides that "An application for compensation under this section must be accompanied or supported by a specialist's report and audiogram or by other evidence of loss of hearing that the Board prescribes".

Where a worker has already applied for compensation for hearing loss under section 6, a separate application under section 7 may sometimes be required. However, it will not be insisted upon if it serves no useful purpose. Therefore, no separate application need be made where all the evidence necessary to make a reasonable decision is available without it.

The original application need not be accompanied by a report and audiogram by a physician outside the Board. The Board will obtain the necessary medical evidence.

EFFECTIVE DATE: March 3, 2003 (as to deletion of references to appeal and reconsideration)
APPLICATION: Not applicable.

#31.40 Amount of Compensation under Section 7

No temporary disability payments are made to workers suffering from non-traumatic hearing loss.

Hearing loss pensions are determined on the basis of audiometric tests conducted at the Audiology Unit of the Board or on the basis of prior audiometric tests conducted closer in time to when the worker was last exposed to

hazardous occupational noise if in the Board's opinion the results of such earlier tests best represent the true measure of the worker's hearing loss which is due to exposure to occupational noise.

Section 7(3.1) of the Act provides:

"The board may make regulations to amend Schedule D in respect of

(a) the ranges of hearing loss,

(b) the percentages of disability, and

(c) the methods or frequencies to be used to measure hearing loss."

Where the loss of hearing amounts to total deafness measured in the manner set out in Schedule D, but with no loss of earnings resulting from the loss of hearing, Section 7(2) provides that compensation shall be calculated as for a disability equivalent to 15% of total disability. Where the loss of hearing does not amount to total deafness, and there is no loss of earnings resulting from the loss of hearing, Section 7(3) provides that compensation shall be calculated as for a lesser percentage of total disability, and, unless otherwise ordered by the Board, shall be based on the percentages set out in Schedule D. Schedule D is set out below.

SCHEDULE D

Non-Traumatic Hearing Loss

Complete loss of hearing in both ears equals 15% of total disability. Complete loss of hearing in one ear with no loss in the other equals 3% of total disability.

	Percentage of Total Disability	
Loss of Hearing in Decibels Measured in Each Ear in Turn	**Ear Most Affected PLUS Ear Least Affected**	
0-27	0	0
28-32	0.3	1.2
33-37	0.5	2.0
38-42	0.7	2.8
43-47	1.0	4.0
48-52	1.3	5.2
53-57	1.7	6.8
58-62	2.1	8.4
63-67	2.6	10.4
68 or more	3.0	12.0

The loss of hearing in decibels in the first column is the arithmetic average of thresholds of hearing measured in each ear in turn by pure tone, air conduction audiometry at frequencies of 500, 1000 and 2000 Hertzian waves, the measurements being made with an audiometer calibrated according to standards prescribed by the Board.

In assessing permanent disability awards under Section 7, there is no automatic allowance for presbycusis. In some cases, however, the existence of presbycusis may be relevant in deciding whether the worker has suffered a hearing loss due to their employment. The age adaptability factor is not applied to awards made under Section 7.

Where a worker has an established history of exposure to noise at work, and where there are other non-occupational causes or components in the worker's loss of hearing, and where this non-occupational component cannot be accurately measured using audiometric tests, then "Robinson's Tables" will apply. "Robinson's Tables" will only be applied where there is some positive evidence of non-occupational causes or components in the worker's loss of hearing (for example, some underlying disease) and will not be applied when the measured hearing loss is greater than expected and there is only a speculative possibility without evidential support that this additional loss is attributable to non-occupational factors.

"Robinson's Tables" were statistically formulated to calculate the expected hearing loss following a given exposure to noise. In applying these tables, the cumulative period of noise exposure is calculated. A factor for aging is then added. For pension purposes, the resulting calculation is then compared on "Robinson's Tables" to the worst 10% of the population (i.e., at the same levels and extent of noise exposure, 90% of individuals will have better hearing than the worker).

In some cases, it will be found that a worker has already suffered a conductive hearing loss in one ear, unrelated to their work, which might well have afforded some protection against work-related noise-induced hearing loss in that ear. The normal practice in this situation would be to allocate the higher measure in Schedule D (the "ear least affected" column) to the other ear which has the purely noise-induced hearing loss.

A difficulty occurs where the worker is not employed at the time when their disability commenced. If there are no current earnings on which to base the pension, the Adjudicator should generally refer back to the employments in which the worker was most recently engaged and base the pension on their previous earnings thus discovered.

EFFECTIVE DATE: August 1, 2003
APPLICATION: To all section 23(1) assessments and reassessments undertaken with reference to the *Permanent Disability Evaluation Schedule* on or after August 1, 2003.

#31.50 Loss of Earnings Awards under Section 7

Where loss or reduction of earnings results from the loss of hearing, Section 7(4) provides that compensation shall be calculated by reference to the projected loss of earnings, or by another method of estimating loss of earnings or impairment of earning capacity that the Board adopts; but in no case shall the compensation be less than that provided under Subsection (2) or (3).

Compensation is not payable simply because a worker changes employment in order to preclude the development of hearing loss. As with any other occupational disease, there must be physical impairment from the disease before there can be compensation in any form. In other words, compensation is payable for a disability that has been incurred, not for the prevention of one that might occur.

Where a noise-induced hearing loss has been incurred, if a worker then changes employment to a lower paid but quieter job, that triggers consideration by the Board of a loss of earnings pension notwithstanding that it may seem reasonable that with hearing protection, the worker may have stayed at the former employment. There is no obligation to stay in the employment with hearing protection rather than take lower paying work and claim compensation. Compensation in such cases is, as in all other cases, based on physical impairment. The drop in earnings may be the triggering device that renders the worker eligible for compensation, but it is not part of the formula for calculating the amount.

#31.60 Reopenings of Section 7 Pension Decisions

Where the loss of hearing of a worker in receipt of a pension under section 7 is retested and there is a significant change in the worker's hearing, the following applies.

1. Where the retest records a deterioration in the worker's hearing and the new findings warrant an increase under Schedule D of the *Act*, the pension decision is reopened and the pension award is increased.

2. If the retest shows an improvement in the worker's hearing of a degree greater than 10 decibels, the worker's pension decision is reopened. Where this occurs, two further considerations would apply.

    (a) Where the worker has been paid the pension in the form of a lump-sum payment, the worker is advised in writing that his or her hearing has improved to the point where such a payment would no longer appear justified or appropriate. However, in those cases, no attempt is made by the Board to seek a refund.

(b) Where the worker's pension is being paid in the form of a periodic monthly payment, the payments are reduced or terminated, whichever is applicable, and the worker is informed in writing of the reasons and of the right to request a review of the decision by the Review Division.

If the retest suggests there is an improved level of hearing than that upon which the original pension was set, but the improvement is within a range, up to and including 10 decibels, the pension decision is not reopened.

EFFECTIVE DATE: March 3, 2003 (as to references to reopening, review and the Review Division)
APPLICATION: Not applicable.

#31.70 Compensation for Non-Traumatic Hearing Loss under Section 6

A worker will only be entitled to compensation for non-traumatic hearing loss under Section 6(1) if their exposure to causes of hearing loss terminated prior to September 1, 1975. "Neurosensory hearing loss" is one of the occupational diseases listed in Schedule B of the Act. The process or industry described opposite to it is "Where there is prolonged exposure to excessive noise levels".

Section 55 of the *Workers Compensation Act* sets out the time limits within which an application for compensation must be filed. Subsection (4) of the present Section 55 provides:

> "This section applies to an injury or death occurring on or after January 1, 1974 and to an occupational disease in respect of which exposure to the cause of the occupational disease in the Province did not terminate prior to that date."

The result of this provision is that where a worker's exposure to causes of hearing loss terminated prior to January 1, 1974, the present Section 55 does not apply and one must look to the provision which was repealed on the enactment of this section.

Under the previous Section 55 (then numbered 52), a claim is, subject to Subsection (4), barred unless an application for compensation, or in the case of health care, proof of disablement, is filed within one year after the day upon which disablement by industrial disease occurred. The Board has no general power to waive these requirements and extend the time period in which an application must be submitted beyond the period set out in Section 52(4). To determine what is meant by "disablement" in this provision, one must refer back to Section 6(1) of the Act which provides in part that no compensation, other than

health care, is payable in respect of an occupational disease unless the worker is ". . . thereby disabled from earning full wages at the work at which the worker was employed . . ." The one-year time period under the previous and current Section 55 does not begin to run until the worker becomes disabled from earning full wages within the meaning of Section 6(1). It follows that in cases where the exposure to causes of hearing loss terminated prior to January 1, 1974, and no disablement within the meaning of Section 6(1) has yet occurred, health care can always be provided, whether or not an application for compensation has been received from the worker and regardless of the length of time which has elapsed since their exposure terminated. Once the disablement from earning full wages occurs, the worker then has one year to submit an application for compensation (if they have not already done so) or proof of disablement. If no application for compensation or proof of disablement has been received by the end of this period, the worker's claim becomes completely barred even though they may previously have received compensation in the form of health care. If the worker submits proof of disablement, but no application for compensation, by the end of this period only compensation in the form of health care is payable. (12)

#31.80 Commencement of Pension Benefits under Sections 6 and 7

1. The following applies to claims for loss of hearing of non-traumatic origin.

2. Where compensation is being awarded under Section 6, then, subject to Section 55, pension benefits shall be calculated to commence as of the date upon which the worker first became disabled from earning full wages at the work at which the worker was employed.

3. Where compensation is being awarded under Section 7 in respect of a loss of earnings or impairment of earnings capacity, then, subject to Section 55, pension benefits shall be calculated to commence as of the date when the worker first suffered such loss of earnings or impairment of earnings capacity, or as of September 1, 1975, whichever is the later.

4. Where compensation is being awarded under Section 7 but not in respect of any loss of earnings or impairment of earning capacity, then, subject to Section 55, pension benefits shall be calculated to commence as of the earlier of either the date of application or the date of first medical evidence that is sufficiently valid and reliable for the Board to establish a pensionable degree of hearing loss under Schedule D of the Workers Compensation Act. Where the date of application is used as the commencement date, subsequent testing must support a pensionable degree of hearing loss as of the date of application. In no case will pension benefits under Section 7(3) commence prior to September 1, 1975.

#31.90 Assessment of Pensions for Traumatic Hearing Loss under Section 5(1)

Disabilities arising from traumatic hearing loss covered by Section 5 of the Act are assessed in accordance with the Permanent Disability Evaluation Schedule, Items 91 to 103. See Appendix 4, pages A4-6 and A4-7.

To determine the percentage of disability in a case of bilateral traumatic hearing loss, a calculation is first made of the average hearing thresholds in the three frequencies of the speech range, i.e. 500 Hz, 1,000 Hz, and 2,000 Hz. A deduction is then made of 0.5 decibels for each year the claimant's age exceeds 50 to allow for presbycusis. This is done for each ear.
The net decibel loss in each ear is then translated into a percentage of disability by taking the nearest figure in the schedule. For example, if the net loss is 48 decibels, the percentage for 50 decibels is taken, i.e. 1.3%. An enhancement factor is also applied. This involves adding to the percentage of disability which the schedule allots to the poorer ear nine times the percentage it allots to the better ear. (13)

#32.00 OTHER MATTERS

#32.10 Psychological/Emotional Conditions

The Board does accept claims for personal injury where the injury consists of a psychological condition or the psychological condition is a consequence of a physical injury. (14) However, the Board has not recognized any psychological or emotional conditions as occupational diseases related to employment.

#32.15 Alcoholism

Alcoholism and alcohol-related cirrhosis of the liver have not been recognized by the Board as occupational diseases. (15)

Research indicates that many factors may be operative in causing alcoholism. While employment is one of the suggested factors, the evidence does not clearly support a conclusion that employment does have causative significance or that, if it does, it has particular significance over and above the others. It appears rather as just one factor, along with the alcoholic's individual physiology and psychology, their family, social and cultural surroundings and their own personal inability to control consumption.

#32.20 Physical and Emotional Exhaustion

Physical and emotional exhaustion has not been recognized by the Board as an occupational disease. In a claim made for compensation for a state of physical and emotional exhaustion alleged to have been caused by the stress of work, it

was concluded that there was insufficient evidence that employment, as opposed to other factors in the worker's life, were of causative significance in producing this condition. (16)

#32.50 "Date of Injury" for Occupational Disease

For purposes of establishing a wage rate on a claim for occupational disease (determining the average earnings and earning capacity of the worker at the time of the injury), the Adjudicator will consider the occurrence of the injury as the date the worker first became disabled by such disease. A worker will be considered disabled for this purpose when they are no longer able to perform their regular employment duties and as such would in the ordinary course sustain a loss of earnings as a result. This date may or may not correspond with the date the worker was first diagnosed with the occupational disease.

The date of the worker's first seeking treatment by a physician or qualified practitioner for the occupational disease is used for administrative purposes. For example, this date will be used where there is no period of disability. Where the worker's condition was not at that time diagnosed as an occupational disease, the relevant date is the date the occupational disease is first diagnosed. These dates may also, in the absence of evidence to the contrary, be used as the date of disablement for the purpose of determining compensation entitlement under Section 55 of the Act.

EFFECTIVE DATE: October 1, 2007 – Revised to delete reference to assigning a claim number.

APPLICATION: Applies on or after October 1, 2007

#32.55 Time Limits and Delays in Applying for Compensation

A person must apply for compensation for death or disablement due to an occupational disease within the time limits set out in Section 55 of the Act. That person can be the worker or the worker's dependant(s) if the worker has died. People who delay in applying for compensation may lose or limit their right to compensation because the Board can only consider an application on its merits if the requirements of Section 55 are met. One of the purposes of these time limits is to ensure the Board is given early notice of the claim so that the relevant evidence can be obtained when it is more readily available.

A person applying for compensation for an occupational disease must generally do so within one year of the date of death or disablement (in most cases a disablement will precede any death). There are exceptions as noted below. If the worker is alive and if the occupational disease has never caused a disablement, then time has not yet started to elapse for the purposes of Section 55. Section 55(2) says in part:

> (2) Unless an application is filed, or an adjudication made, within one year after the date of . . . death or disablement from occupational disease,

no compensation is payable, except as provided in subsection (3), (3.1), (3.2), and (3.3).

Under the terms of a predecessor to the current Section 55, a claim must be denied if a person applies to the Board more than one year after the worker's most recent disablement or after the worker's death if:

- the death occurred before January 1, 1974, or
- the most recent disablement occurred before January 1, 1974 and the exposure to the cause of the occupational disease in British Columbia did not continue beyond that date.

#32.56 Applicants Who File Within Three Years

The Board may consider paying compensation benefits even though a person applies more than one year after the death or disablement due to the occupational disease if:

- he or she applies within three years after the death or disablement, and

- special circumstances precluded applying within one year.

Section 55(3) says:

> (2) If the board is satisfied that there existed special circumstances which precluded the filing of an application within one year after the date referred to in subsection (2), the board may pay the compensation provided by this Part if the application is filed within 3 years after that date.

For a discussion of special circumstances, see #93.22.

If special circumstances do not exist, the Board cannot consider the claim, unless it meets Section 55(3.2), because the application will be out of time.

#32.57 Applicants Who File Beyond Three Years

A person who applies more than three years after the date of death or disablement due to the occupational disease might still receive compensation benefits under Section 55(3.1). If special circumstances precluded applying within one year, the Board may still consider starting compensation benefits from the date the Board received the application. However, the Board cannot consider compensation benefits for periods before that date, unless the claim meets Section 55(3.2).

Section 55(3.1) says:

(3.1) The board may pay the compensation provided by this Part for the period commencing on the date the board received the application for compensation if

(a) the board is satisfied that special circumstances existed which precluded the filing of an application within one year after the date referred to in subsection (2), and
(b) the application is filed more than 3 years after the date referred to in subsection (2).

As stated before, if special circumstances do not exist, the Board cannot consider the claim, unless it meets Section 55(3.2), because the application will be out of time.

#32.58 Newly Recognized Occupational Diseases

As noted in policy item #25.00, it is often more difficult to determine whether a person's employment caused a disease than to determine whether it caused a personal injury. Our knowledge about the role a particular kind of employment may have in causing various diseases changes over time. In recognition of this difficulty, part of section 55 applies only to claims for occupational disease.

The Board may consider paying compensation benefits for a death or disablement due to an occupational disease if all three of the following conditions apply:

1. At the time of the worker's death or disablement, the Board does not have sufficient medical or scientific evidence to recognize the disease as an occupational disease for this worker's kind of employment (even though the Board may have recognized it as an occupational disease for other kinds of employment).

2. The Board subsequently obtains sufficient medical or scientific evidence to cause it to recognize the disease as an occupational disease for this worker's kind of employment.

3. The application for compensation is made within three years after the date the Board recognized the disease as an occupational disease for this worker's kind of employment.

Section 55(3.2) says:

(3.2) The Board may pay the compensation provided by this Part if

(a) the application arises from death or disablement due to an occupational disease,

(b) sufficient medical or scientific evidence was not available on the date referred to in subsection (2) for the Board to recognize the disease as an occupational disease and this evidence became available on a later date, and

(c) the application is filed within 3 years after the date sufficient medical or scientific evidence as determined by the Board became available to the Board.

If, after July 1, 1974, and before August 26, 1994, the Board has considered an application and has determined that all or part of the claim cannot be paid because of the wording of section 55 then in effect, the Board may now under section 55(3.3) reconsider the claim and pay compensation for those periods previously denied if it meets the requirements of section 55(3.2).

Section 55(3.3) says:

> (3.3) Despite section 96(1), if, since July 1, 1974, the Board considered an application under the equivalent of this section in respect of death or disablement from occupational disease, the Board may reconsider that application, but the Board must apply subsection (3.2) of this section in that reconsideration.

For example, in the 1970s sufficient medical or scientific evidence was not available for the Board to recognize an association between exposure to coal tar pitch volatiles in aluminum smelters and an excess risk of bladder cancer. It was not until the late 1980s that sufficient evidence became available for the Board to recognize such an association. (However, the Board had earlier recognized that there was an association between bladder cancer and prolonged exposure to certain chemicals used primarily in the manufacture of rubber and dyes. In 1980 "primary cancer of the epithelial lining of the urinary bladder" was added to Schedule B, with a corresponding presumption in favour of causation where the worker had prolonged exposure to any of three listed chemicals.) On March 13, 1989, the Board issued a policy directive recognizing bladder cancer as an occupational disease for workers employed in aluminum smelting, dependent on the concentration and length of exposure to coal tar pitch volatiles.

Section 55(3.2) allows the Board to consider the payment of compensation benefits for any worker disabled by bladder cancer who was exposed to sufficient doses of coal tar pitch volatiles while employed in the aluminum smelting industry if:

- the exposure did not end before January 1, 1974, and

- the Board received the application not later than March 13, 1992.

Section 55(3.3) allows the Board to reconsider any claims for bladder cancer that meet the requirements of section 55(3.2) and to pay compensation for any periods previously denied because of the wording of the earlier section 55 in effect since July 1, 1974. Sections 55(3.2) and (3.3) went into effect on August 26, 1994. If a claim for bladder cancer is filed after March 13, 1992, then the requirements of sections 55(2), (3), or (3.1) must be met before compensation can be paid.

EFFECTIVE DATE: March 3, 2003 (as to new wording of section 55(3.3))
APPLICATION: Not applicable.

#32.59 Discretion to Pay Compensation

As stated in policy item #93.22, even though special circumstances may have precluded the filing of the application within one year, the Board has discretion under section 55 whether or not to pay compensation. In exercising that discretion, the Board considers whether the time elapsed since the death or disability due to the occupational disease has prejudiced its ability to investigate the merits of the claim, including determining whether the worker was disabled from earning full wages at the work at which he or she was employed.

The Board considers the availability of evidence, such as:

- medical records about the worker's state of health at relevant times (cause of death in the case of a deceased worker)
- employment records that may document exposures to contaminants or hazardous processes, or periods of disability that may have been due to the occupational disease
- evidence from co-workers or others who may know about the worker's employment activities.

The Board will generally decide not to pay compensation if so much time has elapsed that it cannot reasonably obtain sufficient evidence to determine whether:

- the worker's disease was causally connected to the employment, or
- the worker was disabled by the disease when claimed.

A request for review by the Review Division may be made on a Board decision not to pay compensation.

Where a worker has experienced more than one period of disablement from the occupational disease for which the worker intends to claim, then each period of disablement will have to be individually considered to determine if the requirements of section 55 are met with respect to that period.

EFFECTIVE DATE: March 3, 2003 (as to reference to Review Division)
APPLICATION: Not applicable.

#32.60 Preventive Measures and Exposures

Once the basic requirements of a claim for a compensable injury or occupational disease have been met, the Board can accept responsibility for reasonable preventive or curative measures which are a normal part of the treatment of the resulting condition. For example, if a nurse pricks his or her finger with a contaminated hypodermic needle, just used for injecting a patient suspected of having infectious hepatitis, the Board will pay for a gamma globulin injection. This would be so even if the actual needle prick itself did not require treatment.

In order for an exposure to a disease or contaminant to be compensable, the worker must either sustain a personal injury or suffer from an occupational disease. An exposure which does not result in a personal injury or occupational disease does not meet the requirements of the Act in terms of compensability. Section 1 provides that "occupational disease" includes "*disablement* resulting from exposure to contamination" (emphasis added). No matter how appropriate it may be for a worker to be provided with prophylactic health care, particularly following an exposure to an infectious agent, the Board does not have the statutory authority to pay for such health care where the worker has not sustained a personal injury or is suffering from an occupational disease, even if the exposure places the worker at risk for developing an occupational disease.

In the event of such an exposure, any medical or other expenses that the worker may incur to prevent the onset of an injury or disease must remain the responsibility of the worker or the employer. For example, the Board would not pay for a measles vaccine for a nurse who came in contact with a patient who had that disease. In those circumstances, the nurse has not sustained either a personal injury nor an occupational disease. In one case, a laboratory assistant accidentally spilled over a hand blood from a patient infected with hepatitis. The worker already had an infected hangnail on that hand. The Board could not accept responsibility for the subsequent treatment with gamma globulin as there was no evidence of the worker suffering an injury or occupational disease. The treatment was for the purpose of preventing the onset of a disease.

It may help to further illustrate these principles. The Board would not pay for preventive health care benefits with respect to the following exposures (unless an occupational disease results):

- an ambulance attendant who has the blood of a suspected Hepatitis B carrier splashed onto a hand which had pre-existing cuts from gardening at home;
- a pipefitter who unknowingly works in an area containing asbestos insulation.

The Board would pay for reasonable health care benefits with respect to the following occupational exposures:

- a lab technician who in the course of employment cuts a finger on the sharp edge of a broken specimen bottle;

- a teacher who contracts ringworm at the time of an outbreak of this disease in the classroom.

No compensation is payable to a worker who withdraws from work or changes employment as a result of the worker believing (no matter how well-founded that belief may be) that further exposure to the conditions at work would create a risk of causing an injury or disease which does not yet exist. This is so even if the belief is based on information which comes from the Board itself.

Temporary total or temporary partial disability benefits are payable for a compensable occupational disease until any temporary disability terminates or until the worker's symptoms become stabilized. Such benefits are not payable to a worker who remains off work or who changes employment to prevent a reoccurrence of an occupational disease that has resolved, or to prevent an aggravation, activation, or acceleration of an occupational disease which has stabilized or plateaued. However, vocational rehabilitation assistance may be provided to a worker in this situation (see #86.30). Where the worker is left with a permanent impairment, the worker may be entitled to a permanent disability pension.

#32.80 Federal Government Employees

The rights of employees of the Federal Government to compensation for occupational disease are set out in Section 4 of the *Government Employees Compensation Act.* This provides that an employee who . . . is disabled by reason of an industrial disease due to the nature of the employment; and . . . the dependants of an employee whose death results from such . . . industrial disease . . . are, notwithstanding the nature or class of such employment, entitled to receive compensation at the same rate and under the same conditions as are provided under the law of the province where the employee is usually employed. Section 4(4) of this Act applies a similar provision to railway employees of the Federal Government.

The meaning of "employee" is discussed in #8.10. The place where an employee is usually employed is discussed in #24.00.

#32.85 Meaning of "Industrial Disease" under Government Employees Compensation Act

"Industrial Disease" is defined in Section 2 to mean "any disease in respect of which compensation is payable under the law of the province where the employee is usually employed respecting compensation for workmen and the dependents of deceased workmen".

Any employee who is disabled by reason of any disease that is not an occupational disease but is due to the nature of the employment and peculiar to or characteristic of the particular process, trade or occupation in which the employee is employed at the time the disease was contracted (17) and the dependants of a deceased employee whose death is caused by reason of such a disease, are entitled to receive compensation at the same rate as they would be entitled to receive under the *Government Employees Compensation Act* if the disease were an occupational disease, and the right to and the amount of such compensation is determined by the same board, officers or authorities and in the same manner as if the disease were an occupational disease.

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)

CHAPTER 5

WAGE - LOSS BENEFITS

#33.00 INTRODUCTION

Wage-loss benefits are payable where an injury or disease resulting from a person's employment causes a period of temporary disability from work. These benefits usually commence shortly after the initial acceptance of a claim and may be total (Section 29) or partial (Section 30). They cease when the claimant recovers from the injury or the condition becomes a permanent one. In the latter event, the claimant is entitled to be assessed for a permanent partial disability pension. This entitlement is dealt with in Chapter 6.

Wage-loss benefits are calculated on the basis of a worker's "average earnings". The computation of average earnings is dealt with in Chapter 9.

#34.00 TEMPORARY TOTAL DISABILITY PAYMENTS

Where a temporary total disability results from an injury, Section 29(1) provides that the compensation consists of periodic payments to the injured worker equal in amount to 75% of her or his average earnings.

#34.10 Meaning of Temporary Total

It is obvious that for every claim there must be physical impairment as the result of a work-related injury or occupational disease. It is the instigating factor without which the system never comes into play. Once it is found that a worker has suffered such an impairment it becomes necessary to determine the extent of compensation payable, i.e. the consequences of the impairment. There are, therefore, two considerations on every claim. Firstly, the impairment itself, and secondly, the entitlement to benefits arising from the impairment.

The words "temporary", "permanent", "partial", and "total" found in Sections 22, 23, 29 and 30 are applicable only to the impairment component of the claim and are not to be related to its compensable effects. To differentiate between the "temporary" and "permanent" consequences of an impairment is possible only by reference to the impairment itself. Once it has been determined that a claimant has a temporary or permanent, partial or total medical impairment, benefits to compensate for the consequences of that impairment shall be paid in accordance with the requirements of the appropriate section of the Act.

It follows from the above that in order to be eligible for benefits under Section 29(1) a worker must have a temporary total physical impairment as a result of the injury.

A "temporary" physical impairment is one which is likely to improve or become worse and is therefore not stable. Realistically speaking, ongoing change is a natural feature of human physiology. Impairments resulting from an injury commonly deteriorate or improve over a period of years. However, an impairment is not considered temporary simply because it is possible that, as the worker becomes older, the condition may change or the worker may have to undergo further treatment. It only remains temporary when such a change can reasonably be foreseen in the immediate future. (1)

Most compensable injuries and diseases involve an initial period of temporary disability during which wage-loss benefits are paid. This disability will usually improve in time until it disappears entirely or becomes permanent. However, in the case of some diseases there is no initial period of temporary disability; the condition is permanent right from the beginning and no wage loss is payable. Raynaud's Phenomenon, is one of these diseases. There are also others, for example, hearing loss caused by exposure to industrial noise. The worker's only entitlement in these cases is to be assessed for a permanent partial disability award.

Even if a claimant is found to have a temporary total physical impairment, no wage-loss payments will be made unless that impairment in fact causes the cessation of regular employment. If the impairment causes only a partial cessation from this work or some alternative light work is taken up, benefits are calculated under Section 30.

References to "physical impairment" in the above paragraphs include "psychological impairment" where the claimant's disability is psychological in nature.

#34.11 Selective/Light Employment

STATEMENT OF PRINCIPLE

Selective/light employment is a temporary work alternative, offered by an employer, that is intended to promote a worker's gradual restoration to the pre-injury level of employment. The Board supports selective/light employment as an important component of a worker's rehabilitation and recognizes the value of maintaining an injured worker's positive connection to the workplace. It has been amply demonstrated that the earlier a worker is able to safely return to productive employment following an injury, the more likely he or she is of obtaining maximum recovery.

CRITERIA

To ensure that the early return-to-work is appropriate, all selective/light employment arrangements must meet the following conditions:

- While the compensable injury may temporarily disable the worker from performing his or her normal work, the worker must be capable of undertaking some form of suitable employment.

- The work must be safe for the injured worker to perform. The worker's attending physician must be apprised of the nature of the work and conclude that it will neither harm the worker nor slow recovery. Should the attending physician be unable or unwilling to provide the required advice, a Board medical advisor must make the necessary determination.

- The work must be productive. Token or demeaning tasks are considered detrimental to the worker's rehabilitation.

- Within reasonable limits, the worker must agree to the arrangement.

INTERVENTION

The Board recognizes that the successful development of selective/light employment opportunities depends on the cooperation of all parties in the workplace. In the following situations, the Board will intervene to determine if a particular offer of selective/light employment is suitable:

- The worker and employer are in disagreement over the terms of the return-to-work.

- There is a request for intervention by either the worker or employer.

- The Board officer adjudicating the claim considers that further inquiry is required.

ADJUDICATION

On intervention, the Board's evaluation will be based on, but not limited to, a detailed description of the employment being offered, including the physical requirements and detailed medical information outlining the worker's physical restrictions and medical requirements.

Where a worker refuses to accept the offer, the Board will consider the reasons for refusal and determine if they are reasonable. In making this determination, a Board officer will give regard to the nature of the work, and the worker's physical restrictions and medical requirements. Notwithstanding, Board officers have discretion to consider additional factors or evidence relevant to the case, such as transportation (see policy item #82.00) and child-care (see policy item #84A.00).

Where a worker accepts suitable selective/light employment, benefit entitlement will be determined under Section 30 of the *Act*.

Should the Board determine that the worker's refusal is unreasonable, benefit entitlement may be determined under Section 30 of the *Act*.

#34.12 Claimant in Receipt of Permanent Disability Pension

Wage-loss benefits are terminated when the claimant's condition becomes permanent and prior to the assessment of any pension. However, they may again become payable because a further work injury or a natural relapse in the condition for which the pension is being paid causes a further period of temporary disability.

With regard to the latter situation, it is recognized that no condition is ever absolutely stable or permanent; there will commonly be some degree of fluctuation. Nevertheless, a pension will be awarded when, though there may be some changes, the condition will, in the reasonably foreseeable future, remain essentially the same. The fluctuations in the condition of a worker receiving a pension may be such as to require the worker to stay off work from time to time. The question then arises whether wage-loss benefits should be paid for these periods. If the fluctuations causing the disability are within the range normally to be expected from the condition for which the worker has been awarded a pension, no wage loss is payable. The pension is intended to cover such fluctuations. Wage loss is only payable in cases where there is medical evidence of a significant deterioration in the worker's condition which not only goes beyond what is normally to be expected, but is also a change of a temporary nature. If the change is a permanent one, the worker's pension will simply be reassessed.

#34.20 Minimum Amount of Compensation

Wage-loss compensation cannot be less per week than the minimum set out below, unless the worker's average earnings are less than that sum per week, in which case compensation is paid in an amount equal to average earnings. (2)

			$ Per Week (Net)
July 1, 2000	—	December 31, 2000	292.90
January 1, 2001	—	June 30, 2001	298.63
July 1, 2001	—	December 31, 2001	303.32
January 1, 2002	—	June 30, 2002	304.36

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

Consider, for example, the case of an injury occurring on July 2, 1986, when the minimum amount of wage-loss compensation was $201.40 (net) per week.

Worker's Actual Weekly Earnings	Weekly Compensation (Net)
$268.53	$201.40
220.00	201.40
199.00	199.00 (100%)

The minimum is subject to Consumer Price Index increases. However, these increases only apply to injuries or disablements occurring after they come into force. Existing payments are not automatically increased to a new minimum, although they may be the subject of Consumer Price Index increases in their own right.

#34.30 Commencement of Payment

Section 5(2) provides that "Where an injury disables a worker from earning full wages at the work at which the worker was employed, compensation is payable. . . . from the first working day following the day of the injury; but a health care benefit only is payable . . . in respect of the day of the injury."

While the plain wording of the section would seem clearly to indicate that "day of the injury" means calendar day, the Board finds that the intention of the legislation is not to provide payment for the "shift" on which the worker is injured but to provide payment for any subsequent "shift" on which the worker is disabled. Payment of compensation, therefore, will commence effective the shift next following the shift on which the worker is injured.

#34.31 Worker Continues to Work After Injury

If a worker continues to work beyond the day of the injury, no compensation is payable until it actually causes a lay-off from work. If the worker works or is paid for part of the day on which the lay-off occurs, the amount of compensation paid for that day is as follows:

(a) if he or she works or is paid for one quarter of the day or less, compensation is paid for the full day;

(b) if he or she works or is paid for more than one quarter but less than three quarters of the day, compensation is paid for half the day;

(c) if he or she works or is paid for three quarters of the day or more, compensation is not paid for the day.

Except where Section 34 is being applied, (3) the employer is not refunded any money paid to the worker for time not worked on the day when he or she lays off work.

The above rules apply equally where the claimant becomes disabled from working following a recurrence of a compensable condition.

#34.32 *Strike or Other Lay-Off on Day Following Injury*

In cases where a worker's job would not have been available during a period of disability, or for some reason the worker cannot or will not be returning to the prior job upon recovery, the following general guidelines will apply.

1. Where the injury disables the worker beyond the day of the injury and this results in an actual loss of earnings or a potential loss of earnings, the requirement of Section 5(2) will be met and wage-loss compensation will be paid.

2. Where the disability beyond the day of injury does not result in any actual or potential loss of earnings, the requirements of Section 5(2) will be deemed to have not been met.

In interpreting "potential loss" no rigid rules can be established since every case will have to be determined on the information received. In situations where there is a lay-off due to lack of work, a worker would normally be considered as having suffered a potential loss. The position would be similar where a partially disabled worker has continued work on light work and has been laid off due to a lack of work, but payments on such a claim would be considered under Section 30 of the *Act*. The general expectation in those situations is that the claimant would, if not injured, have immediately sought new employment and the Board should not speculate as to if and when it would have been found. If, however, there is evidence to rebut this general expectation, the Board may conclude in a particular situation that there was no actual or potential loss. For example, suppose a homemaker has been injured in the course of a single day's work at a polling station during an election and has no other attachment to the labour force whatsoever. The homemaker would not normally be available on the general labour market beyond the one day of work at the polling station.

There are other situations where, immediately following the lay-off, it would not normally be expected that the worker would seek alternate work, for example, strikes, a statutory holiday, weekends or normal days off, vacations or absences required for medical treatment unrelated to the work injury. It will normally be considered that there is no loss or potential loss in such cases. Again, however, the opposite conclusion may be reached if there is evidence that the claimant would have undertaken alternate work but the injury prevented it.

It should be made clear that the above rules only apply at the point of the original lay-off. Once the Board has commenced the payment of temporary disability benefits, it does not normally discontinue them simply because, irrespective of the injury, the claimant would not have been working for some period of time. This applies even in cases where the claimant recovers from the initial disability and benefits are terminated but the claimant subsequently suffers a recurrence within three years of the compensable condition. The fact that the claimant is, for example, on strike at the time of the recurrence does not bar the payment of benefits for temporary total disability.

#34.40 Pay Employer Claims

Section 34 provides that "In fixing the amount of a periodic payment of compensation, consideration must be had to payments, allowances or benefits which the worker may receive from the worker's employer during the period of the disability, including a pension, gratuity or other allowance provided wholly at the expense of the employer, and a sum deducted under this section from the compensation otherwise payable may be paid to the employer . . ."

The section does not provide that any payment made by the employer shall be deducted from the compensation, or that any compensation deducted shall be paid to the employer. It requires that the Board must consider the matter, and that any compensation deducted under this section may be paid to the employer. The section is permissive, not mandatory, and the question is, therefore, in what circumstances a deduction should be made.

In practice, employers who continue paying full wages to disabled workers are reimbursed in amounts equal to the compensation that would normally be paid to their employees. No refund is made for the difference between the amount of compensation and the worker's regular salary. If an employer continues to pay 25% of a worker's salary or less, full wage-loss payments are made to the worker and no refund made to the employer.

Refunds are made to all employers except for the Federal Government. However, in any case where the Federal Government is not continuing to pay full salary, the Board must pay the wage-loss benefits to the worker.

If a claim is reopened and the worker is carried on full salary by a different employer from the employer at the time of the original injury, the new employer is reimbursed to the same extent as the original employer would have been. This applies even though the original or new employer is an agency or department of the Federal Government.

If an employer has any outstanding liability to the Board for assessments the amount of the liability is deducted from any payments made to the employer.

#34.41 Vacation Pay

If a vacation period or statutory holiday occurs while a worker is receiving wage-loss benefits, the Board continues to pay those benefits or, in the case of a pay employer claim, to the employer.

#34.41A Vacation Pay School Teachers

School teachers are paid an annual salary by School Boards, but the salary is usually paid by dividing it into ten equal payments. Prior to February 28, 1975, the Board's policy was that no wage-loss benefits be paid for the vacation months, July and August, because there was no loss of earnings in those months. The only exception was where the school teacher could provide evidence that alternative employment was going to be undertaken during the vacation and because of the injury the school teacher was prevented from doing so. Since February 28, 1975, the Board's policy has been to continue wage loss in the vacation months, but to make these payments to the employer where, as is usually the case, the employer continues the teacher's salary during the disability. If the employer ceases to pay the teacher for a period because of a lay off or for budgetary reasons, payments by the Board are made direct to the teacher in that period. Payments could also be made directly to the teacher where there was evidence of an additional loss of earnings in the summer months because of the disability, but only then to the extent that the total earnings did not exceed the statutory maximum. The same principles apply to other School Board employees paid on the same basis as teachers.

#34.42 Termination Pay

The language of Section 34 is broad enough to cover termination pay.

In a Board decision, the claimant suffered a compensable injury on October 28. On October 30, the employer terminated the service of the claimant, and

pursuant to Section 19 of the *Mines Act*, the claimant received a termination payment roughly equivalent to wages for one month. The Board rejected an application that the compensation payments attributable to the month of November should be paid to the employer under Section 34.

This was not a voluntary payment by the employer. It was termination pay required by law. If the claimant had been fit to do so, he would have been free in early November to take any other job that he could find, receive full wages in respect of that job and still be entitled to the termination pay. In other words, by the law of the Province, he was entitled to be paid twice over the month of November. Given his disability, he could not do that. But upon being fit again to return to work, he is in the position of one who must find new employment. Termination pay is intended to allow for his being in that position.

This relates only to termination pay under the *Mines Act*. Other arguments may be relevant with regard to other kinds of termination payments. However where the payment is of a similar type or category in that it results from a legislative requirement or a contractual agreement, it will likely be treated in the same manner as that described above.

#34.50 Termination of Wage-Loss Payments

Section 29(1) provides that payments for temporary total disability will continue only so long as the disability lasts. This means that the benefits payable under this section will be terminated when the worker's physical impairment resulting from the injury ceases to be "temporary total", i.e. becomes partial, disappears entirely or stabilizes. If the worker's impairment remains temporary, but is only partial, there may be entitlement to temporary partial disability payments under Section 30(1) of the Act. If the worker's impairment remains but ceases to be temporary, there may be entitlement to a permanent disability award under Section 22 or 23 of the Act, which will commence at the date when the temporary disability payments under Section 29 or 30 were terminated.

#34.51 Other Factors Prevent Return to Employment

The general rule is that, while a claimant's temporary total disability lasts, wage-loss payments continue to be paid even though some event occurs after their commencement which would in any event have meant that the claimant would not be working. Therefore such benefits are not terminated just because there is a strike, vacation, lay-off or the worker reaches official retirement age. On the other hand, as pointed out in #34.32, on a recurrence of a compensable condition occurring more than three years after the injury, wage loss will not be paid for any temporary total disability where there is at that time no actual or potential loss of earnings.

Where a worker in receipt of wage-loss benefits wishes to travel to another place as part of a vacation or for other reasons, the worker should notify the Board. The Claims Adjudicator will then consider the following matters:

(a) If travelling outside the province, the worker should be advised that the Board will not pay in excess of the rates paid for medical treatment in this province.

(b) If there is to be a period with no treatment which may protract recovery, the worker will be advised not to discontinue treatment and that if the worker does so, it may affect entitlement to benefits. The Claims Adjudicator will normally seek medical advice before doing this.

(c) The activities planned for the vacation may suggest that the worker is not disabled or may protract recovery. The Claims Adjudicator will seek medical advice on this and advise the worker accordingly.

There is in general no objection to wage-loss benefits being continued while a claimant is travelling on vacation where that vacation will not hinder or protract recovery. (4)

If a worker's physical impairment has disappeared or stabilized, wage loss must be terminated even though the worker, to prevent further occurrences of his or her condition, remains off work. Compensation is not payable for preventive measures. Alternatively, if the worker's continuing unemployment is due to factors such as fire hazard, seasonal closure, strike or lock-out, benefits are also not payable. Where, however, there is a delay in return to work due to the travelling required back to the place of employment, such as a previously injured worker returning to the home community from a treatment centre elsewhere or a few days until a company doctor clears the worker to return to work, the Adjudicator may extend full wage-loss benefits for a few days beyond the time when the disability ceased. This extension will not be granted if it is concluded that the worker is unnecessarily delaying the return to work.

#34.52 Workers Undergoing Educational or Training Program

Where a worker who has been receiving payments for temporary total or partial disability commences an educational or training program, the question arises as to the continuation of payments by the Board during the course of the program.

There appear to be three different situations:

1. **Retraining or Educational Program Covered by #88.50-#88.53**

   In certain cases, as outlined in #88.50-#88.53, the Board supports retraining or educational programs needed wholly or partly as

rehabilitation for a worker's compensable injury. This applies when a worker is no longer disabled from working and temporary disability payments have terminated, but before she or he can return to work some retraining or educational program is required. Item #34.52, however, is intended to deal with a worker who undertakes a course of training while receiving compensation for temporary disability under Section 29 or 30 of the Act and does not affect the operation of #88.50-#88.53.

2. **Retraining or Educational Program Arranged Prior to Injury**

Prior to injury, a worker may have arranged to undertake a retraining or educational course as part of career development or to become established in some new career. Where the course involves time off work, the worker could be anticipating a period when there will be no earnings save for training allowances payable by the Canada Employment and Immigration Commission or a similar agency. Since this training allowance will continue to be paid whether or not there is a compensable injury, the worker's financial position while taking the course is no worse because of the injury than if there had been no injury. Therefore, the Board considers that a worker is not disabled as a result of the compensable injury and no wage-loss compensation is payable while undertaking a training or educational program arranged prior to the injury.

Under the terms of some collective agreements, a worker continues to receive full wages while undertaking a training program. In such cases, an arrangement is normally made with the Canada Employment and Immigration Commission for any training allowance to be paid to the employer. The Board would expect that an employer would continue a worker's salary while taking the course, regardless of the fact that the worker had previously received a compensable injury. In this case, the worker suffers no financial loss because of the injury while taking the course and no wage-loss compensation is payable. Nor is the employer refunded the continuation of salary paid to the worker during the course.

In some circumstances, it seems that the Canada Employment and Immigration Commission will "top off" a training allowance to bring it up to the amount of a normal Employment Insurance payment. If the Board makes no payment of wage loss to a worker while taking a training course, it is understood that any entitlement of the worker to have the training allowances "topped off" by the Canada Employment and Immigration Commission will be unaffected by the occurrence of the compensable injury. There is, therefore, no justification for the payment of wage-loss benefits during the course.

It is not necessary for all the details of the course as to time, place, subject matter, etc. to have been settled prior to the injury for it to be considered as "pre-arranged". For example, an apprentice may be required to spend some part of each year of the apprenticeship in school. While the exact dates may not be known at the date of injury, the worker must, at that time, clearly anticipate a period at school to be undergone in the near future. It is, therefore, reasonable to apply the rules set out above.

3. **Retraining or Education Program Arranged After the Injury**

A worker may decide after the injury to utilize the time in which he or she is disabled from work to improve education or work skills by undertaking a retraining or educational program. The worker is losing time from work because of the injury and is "disabled" for the purposes of Section 29 or 30. It cannot be said that even if the worker had not been injured he or she would have been taking the program at that particular time and, as a result, suffering a loss of income. The worker is only taking the program at that particular time because of the injury. Therefore, wage-loss payments will be continued in full in addition to any training allowances which the worker is entitled to receive from another government agency.

#34.53 Termination at a Future Date

A worker is not entitled to place absolute reliance on a doctor's probable return to work date. Wage-loss benefits are only payable when the worker actually has a temporary disability. They cannot be paid because, although the worker has no such disability, the doctor some time previously predicted that he or she would be disabled at that time. A doctor's prediction is of assistance to the worker, the employer and the Board to plan their future actions, but there is no guarantee that the prediction will be accurate. A worker who has been told by the doctor that he or she can probably return to work on some future date has a responsibility to monitor the improvement in his or her condition and to return to work before the predicted date if the condition allows it. If the worker is in any doubt, an earlier appointment can always be arranged with the doctor.

If a doctor's prediction of the duration of a worker's disability were accepted as conclusive, it would mean that if a worker continued to be disabled after a predicted return to work date, he or she should nevertheless return to work. Regardless of a doctor's prediction of the length of a disability, wage-loss benefits must continue to be paid for as long as a worker continues to be disabled because of the injury. A doctor's prediction of a worker's return to work can be in error by setting a date either too early or too late. It cannot therefore be regarded as the sole criterion for the payment of benefits and is only one factor to be considered.

As a general rule, decisions relating to compensation should relate to the past and the present, and to continuing situations. A termination date should not normally be set for the future. But there are exceptional cases in which a decision of this kind is justified. The responsibilities of the Board relate not only to claims decisions, but also to rehabilitation. Effective rehabilitation requires that different people should be treated in different ways. All people are not motivated by the same approach. It is possible to conceive of cases in which the Board might feel that a claimant has reached a point of recovery at which he or she is very close to returning to work. The claimant may have a psychological impairment that persuades the Board to continue a convalescent period to enable the claimant to adapt. But a judgment might rationally be made that the claimant is more likely to adapt his or her thinking to a return to work if told of a specified date at which compensation benefits will terminate. But if, at or after that date, no request for review by the Review Division has been filed and it is within the 75-day period for Board reconsiderations, there is evidence that the claimant is still unfit, then the decision can be reconsidered.

EFFECTIVE DATE: March 3, 2003 (as to reference to Review Division and 75-day period for Board reconsiderations)
APPLICATION: Not applicable.

#34.54 When is the Worker's Condition Stabilized

When a worker is medically examined to assess the degree of impairment, the examining doctor must first determine whether the worker's condition has stabilized. The examining doctor will decide whether:

(a) the condition has definitely stabilized;

(b) the condition has definitely not yet stabilized;

(c) he or she is unable to state whether or not the condition has definitely stabilized and

    (i) there is a likelihood of minimal change; or

    (ii) there is a likelihood of significant change.

Having regard to the examining doctor's report and any other relevant medical evidence, the Claims Adjudicator will then decide whether or not the worker's condition is permanent to the extent that a pension should be assessed.

In the case of (a), the condition is considered permanent and the pension is immediately assessed. A condition will be deemed to have plateaued or become stable where there is little potential for improvement or where any potential changes are in keeping with the normal fluctuations in the condition which can be expected with that kind of disability. In the case of (b), the condition is still

temporary and the claimant will be maintained on temporary wage-loss benefits under section 29 or 30 of the *Act*.

In the situations where the examining doctor in (c)(i) above feels there is only a potential for minimal change, the condition will usually be considered as permanent and the pension established immediately on the basis of the prognosis. This approach will be particularly helpful where the disability is itself minor.

The following guidelines operate in (c)(ii) above where there is a potential for significant change in the condition.

1. If the potential change is likely to resolve relatively quickly (generally within 12 months), the condition will be considered temporary and the worker maintained on temporary wage-loss benefits under section 29 or section 30 of the *Act*, and a further examination will be scheduled.

2. If the potential change is likely to be protracted (generally over 12 months), the condition will be considered permanent and the pension assessed and paid immediately on the worker's present degree of disability and the claim scheduled for future review.

The examining doctor may be unable to fit the claimant's condition exactly into one of the categories discussed above. In such a case, the doctor should simply state the findings in terms of the categories as well as possible and the question whether the condition is temporary or permanent will have to be dealt with by the Claims Adjudicator on the merits of the case.

EFFECTIVE DATE: March 3, 2003 (as to deletion of reference to pension review)
APPLICATION: Not applicable.

#34.60 Payment Procedures

The decision whether wage-loss benefits are payable, the duration of those payments, and their amount, is made in the first instance by the Board officer. The procedures followed in making this decision, including the rules of evidence followed, are dealt with in Chapter 12.

Payments of wage-loss benefits are usually made every two weeks by cheque. The cheques are normally mailed to the worker. When a payment has been lost or stolen, or otherwise not received or cashed by the worker, the worker may request a reissue of the payment, but the Board will require a written and signed declaration of this from the worker before a reissue will take place.

Where a worker disagrees with the amount of wage-loss or pension and returns the cheque, or refuses to accept the cheque, the Board will not negotiate regarding the acceptance of the cheque. In such circumstances the worker is notified of the right to request a review from the Review Division with regard to the matter on the claim to which there is an objection. This policy also applies to those cases where a worker has elected to receive his or her pension cheque by electronic direct bank deposit.

Where, following a medical examination at the Board or the receipt of other reports, it is concluded that the worker is capable of resuming employment immediately, she or he will be notified as soon as possible. The Board recognizes that it would not be fair to delay the notification when the claimant might be looking for employment in the meantime.

Where wage-loss benefits have been paid for a period of disability in excess of 13 weeks and it is not clear that the worker has actually returned to work, the Board officer does not final wage-loss compensation benefits until there has been a discussion with the worker regarding this decision. In some cases it will also be necessary to involve the services of the Rehabilitation Consultant where there are re-employment problems.

EFFECTIVE DATE: March 3, 2003 (as to reference to the Review Division)
APPLICATION: Not applicable.

#35.00 TEMPORARY PARTIAL DISABILITY PAYMENTS

Section 30(1) provides that "Where temporary partial disability results from the injury, the compensation shall be a periodic payment to the injured worker equal in amount to 75% of the difference between the average earnings of the worker before the injury and the average amount which he or she is earning or is able to earn in some suitable employment or business after the injury, and must be payable only so long as the disability lasts."

#35.10 Meaning of Temporary Partial

The meaning of "temporary partial" is governed by the principles set out in #34.10. The result is that in order to be eligible for benefits under Section 30(1) a worker must have a temporary partial physical impairment as a result of the injury.

Claimants will also be considered to have a temporary partial disability when, even though they would ordinarily be considered as temporarily totally disabled, they do in fact continue to carry out their previous jobs in part or perform some other type of light work.

#35.11 Procedure for Determining Whether Worker is Temporarily Partially Disabled

The decision as to whether a disability has resolved to a point of recovery where it is deemed to be only "partial" shall be made by the Adjudicator on the best evidence available. In many cases it may be appropriate to rely solely upon reports of the claimant's attending physician or a consulting specialist. Advice on the contents of such reports should be sought from the Board Medical Advisor who might consider it prudent to contact the attending physician for further discussion.

In other cases, it might well be necessary to have the worker examined by a Board Medical Advisor.

In either case, what must be determined is whether the worker's medical condition has resolved to the point where he or she is no longer to be considered "totally" disabled and it would be to his or her advantage to begin to consider re-entry into the work force. It will not be necessary for the Adjudicator to wait passively for notification by an attending physician or consulting specialist before proceeding to deal with the claimant's condition as a "partial" rather than "total" condition. There may be cases where the Adjudicator should instigate an examination of the claimant in order to determine the extent of the condition, particularly where recovery from the injury appears to be unusually protracted, or it appears that other health or social problems are complicating the potential for re-employment, or where medical reports tend to indicate onsiderable improvement in the claimant's medical condition without specifically recommending a return to some form of employment.

In any case where it is deemed necessary to have the claimant examined by a Board Medical Advisor, claims will be referred promptly for that purpose and the examination will be given priority. Where such an examination is conducted, the Board Medical Advisor will be required to indicate whether the worker is:

(a) still totally disabled;

(b) fully recovered;

(c) temporarily partially disabled;

(d) suffering from a residual permanent disability which shows no reasonable likelihood of change.

Where it is found that the claimant is temporarily partially disabled, the Board Medical Advisor will:

(a) estimate the period required to full recovery or stability;

(b) recommend a time for a future examination and record that on the claim;

(c) specify any medical restrictions to re-employment, such as limitations on lifting activities, with the reason for such restrictions;

(d) record any medical or other factors found in the examination which are considered significant in the determination of the claimant's recovery process.

Where the Adjudicator intends to rely for his or her decision upon a report from the claimant's attending physician or consulting specialist, these same general questions should be clarified through contact with that physician before any further action is taken. Again, such contact should be by the Board Medical Advisor or by the Adjudicator after consultation with the Board Medical Advisor.

Where a worker is medically judged to be only partially disabled and the condition remains temporary, any further wage-loss payments should then be processed under Section 30 of the Act, and the claim shall be referred immediately to a Rehabilitation Consultant indicating that benefits are now being paid under that section. This referral must be done in all cases, irrespective of whether the claim has previously been referred to a Rehabilitation Consultant.

The Adjudicator will then send a letter to the worker, with a copy to the employer and doctor, advising:

(a) that the worker is considered to be only partially disabled;

(b) that further wage-loss benefits will be paid on the basis of the difference between the earnings before the injury and what the worker is then earning, or will be able to earn, whichever is considered appropriate;

(c) that the worker will be contacted and interviewed by a Rehabilitation Consultant who will assist in efforts to return to work;

(d) the proposed date of the next examination and therefore the length of time for that phase of payments under Section 30.

#35.20 Amount of Payment

Section 30 provides for payment of partial or total wage-loss benefits where a worker is only partially disabled. Having made the determination, on medical grounds, that a worker is no longer totally disabled but in fact has reached a point in the recovery process where he or she is deemed to be only partially disabled, that section requires that wage-loss benefits be paid on the basis of two measures:

(a) the average earnings before the injury, less the amount which the worker is now earning; or,

(b) the average earnings before the injury, less the amount which the worker is now able to earn.

The amount paid will be 75% of whichever of (a) and (b) is the less.

The amount of the payment will be the decision of the Adjudicator. During the period of temporary partial disability, the Rehabilitation Consultant will provide the Adjudicator with a report every month, or at shorter intervals where mutually considered advisable. To ensure income continuity where the worker is not employed, the first two-week payment may be processed in advance of the receipt of the Rehabilitation Consultant's report. The report will indicate what the worker actually earned in the intervening period, if anything, and will estimate what the worker could have earned in the opinion of the Rehabilitation Consultant. Payments by the Adjudicator will be based upon this information and on any other evidence considered significant.

In determining temporary partial disability entitlement under Section 30 of the *Workers Compensation Act*, no earnings losses incurred are considered where such losses are in excess of the amount of personal optional protection purchased.

The Adjudicator shall, in all cases, make the claimant aware of the reasons for the payments being made under Section 30 and more particularly, when only partial payments are made and the claimant is not working.

#35.21 Availability of Jobs

In estimating what a worker could have earned, the Rehabilitation Consultant will consider such factors as:

(a) the medical condition of the claimant and the limitations this condition places upon re-employment;

(b) the availability of work in the claimant's community or, where appropriate, in the Province at large;

(c) any personal limitations upon re-employment, such as age, lack of required skills or language;

(d) any external limitations upon re-employment, such as the possibility of loss of pension entitlement or plant seniority;

(e) the worker's own efforts and cooperation in becoming re-employed;

(f) general or local depressed economic conditions which might have restricted the claimant's re-employment irrespective of the occurrence of the injury.

The legislation quite clearly envisages a distinction between Section 30 and 23(3) in determining what jobs are available to a claimant. (5) Section 30 uses

the words, “in some suitable employment” whereas Section 23(3) states, “in some suitable occupation”. The word, “employment” has a connotation of immediacy while “occupation” tends to suggest a more long-term concept. In light of this, the jobs that are looked at in assessing a loss of earnings pension must be available in the long run and must be within the worker’s capability. The jobs that are recommended as being suitable for the worker in calculating a loss of earnings pension need not be available at the time the recommendation is prepared, but should be available to the worker on a fairly regular basis over a reasonable period of time. The measure of what constitutes a reasonable period would depend on the particular circumstances of each claim with a major factor being the worker’s age.

In determining Section 30 benefits, the employment opportunity or opportunities should be available immediately or within the period under review (two weeks, one month) and there should be some certainty that the employment opportunity or opportunities would be open to the worker should he or she choose to apply. It is not appropriate to suggest for example that a “self service gas station attendant’s position is available from time to time in the community and therefore the worker could obtain this job”. This may be an appropriate recommendation in the development of a loss of earnings pension, but it is not suitable for determining Section 30 benefits which are more immediate and for a limited time duration.

With regard to item (f) above, the Board has to determine whether the worker’s employment problem is primarily due to a residual temporary disability or is more likely to be due to the lack of suitable employment occasioned by economic circumstances. It is appreciated that this will frequently be a difficult matter to fully resolve and while specific evidence to support a given decision is desirable, there will inevitably be circumstances which will have to be resolved on the basis of the best combined judgment of the Rehabilitation Consultant and Adjudicator. The general approach followed is to compare the situation of the worker with the worker’s fellow employees.

If the worker’s fellow employees are on a lay-off and also unemployed due to a lack of alternative work resulting from an economic down-turn and had the worker not been injured, he or she also would have been similarly laid off and similarly unemployed, it would be reasonable to assume that the economy is a major factor in the loss of income situation and not totally the injury. As such, the worker should not be entitled to full wage-loss benefits on a “could earn” basis simply on the grounds that the jobs that normally would have been available are not then available due to an economic down-turn. While it could be argued that the worker should not be paid any benefits in order to equate his

or her status with that of fellow workers, it is felt that a payment computed on the basis of the difference between the pre-injury wage rate and the wage rate of the jobs that would otherwise have been available were it not for the down-turn would be more in keeping with the intent of the Act and Board policy. It should be stressed at this point that this approach should not be confused with the situation where the worker's remaining disability makes him or her less viable as a potential candidate for employment in the labour force in competition with other non-disabled workers. In situations such as this, the interpretation of "reasonably available" would require that the worker be paid full benefits on the basis that the work is not reasonably available.

If there has been no lay-off and the worker's fellow employees are still working, and had the worker not been injured he or she also would have continued to be employed, then it is fair to say that even though alternative jobs are not available due to economic factors, the primary cause of the worker's loss stems from the injury. As such, the worker should be entitled to Section 30 benefits up to and including full wage-loss benefits if there are no jobs reasonably available in the period being considered. Jobs that are not available due to economic factors should therefore not be used as a measure of "could earn" to potentially reduce the level of temporary partial disability benefits.

Where a claimant and the Vocational Rehabilitation Consultant are working toward an employment objective and as the result the worker is unable to accept a lower paying alternative job in the interim, to deny full benefits to such a worker would be an inappropriate application of the Board's policies with respect to temporary partial disability benefits. In such a case, the worker and the Rehabilitation Consultant are working toward an objective and this could be frustrated by suggesting that the worker could take a temporary, lesser paying job. Where the Rehabilitation Consultant and the worker are striving to carry out a rehabilitation plan, and all parties are cooperating in good faith, the Rehabilitation Consultant is not required to suggest in his or her recommendation that the temporary partial disability benefits be based on a short-term, temporary, lesser paying job that the worker could do if this is incompatible with the demands and commitment required from a worker to meet the vocational objective.

#35.22 Calculation of Earnings

The average earnings of the claimant before the injury are for the purpose of Section 30 generally calculated in accordance with the Board's practice set out in Chapter 9. Therefore, where the period of temporary disability has gone beyond eight weeks, the rate set at the time of the 8-week rate review will be used. (6) An exception to this is made in computing temporary partial disability

entitlements where a worker returns to the same employer on a suitable employment basis at a reduced wage, and where the rate has been reduced at the 8-week point following the injury. In calculating the worker's loss, the Adjudicator uses the wage rate at the time of the injury and not the 8-week rate set on the basis of average earnings. If the worker returns to a different employer, the 8-week rate is used.

Where, prior to the injury, the claimant was engaged in two occupations, but the injury only disables the claimant from one, the pre-injury earnings are calculated by adding the earnings in both, subject to the statutory maximum. The post-injury earnings are calculated by combining the earnings in the job the claimant continues to carry on, with the earnings (if any) which the claimant is able to earn in some other suitable and available job in the time that would have otherwise been spent in performing the other pre-injury job.

Earnings are, where possible, calculated on a weekly basis. Where, for example, a worker has worked for only one day in a week, the earnings in that day are considered the week's earnings. The worker will not be paid for the other days of that week on the assumption that there were no earnings.

#35.23 Minimum Amount of Compensation

The minimum amount of compensation is calculated in the manner set out in #34.20 for temporary total disability but to the extent only of the partial disability. (7)

Where a worker's earnings are less than the minimum and he is receiving compensation in an amount equal to his earnings, he will receive compensation equal in amount to his loss of earnings in any case where Section 30 applies. The loss will not be reduced by the 75% factor.

#35.24 Workers Engaged in Own Business

Where the claimant is the principal of a small limited company the claimant will often continue to work following a compensable injury. Though unable to perform the former heavier work, the claimant can still perform administrative and other light work. Full wage-loss benefits will not be paid by the Board just because the claimant cannot perform the heavier work. As the claimant is doing some remunerative work, Section 30 requires that it be taken into account, and that only partial wage-loss benefits be paid.

The general position of the Board is that, in determining earnings on a claim, dividends from investments in corporations are not considered. The Board accepts at face value the wages paid by a company to its principal if they are

reasonably related to what is done. However, where the principal receives nominal or no wages for the work done the Board will estimate what it considers to be a reasonable wage for that work.

In determining wage rates of principals for compensation purposes, regard is primarily had to the earnings rate reported by the employer.

If reported earnings are being received by a principal's or shareholder's spouse or child, then it should normally be considered for compensation purposes that the earnings belong to the spouse or child and not the principal or shareholder. The same applies if information of this nature has been provided on Income Tax Reports.

In making reports of this nature for Income Tax purposes, the company is asserting that the principal's or shareholder's spouse or child did work in the business and did earn the money paid. The Board is required to consider any evidence which may show that this assertion is incorrect and to make its own determination. However, the Board is entitled to rely upon this assertion unless there is good evidence to the contrary. Even if, upon investigation, the evidence shows that the spouse or child did not work for the company, that in itself does not mean that the payments to the spouse or child were earnings of the principal or shareholder. There could be any number of other reasons why the company might make payments to the spouse or child.

In compensating the principal of a small limited company, the Board's obligations extend only to the losses suffered in the capacity of employee. Wage-loss compensation cannot be paid to reflect any detrimental effect that the injury may have on the company's business.

Similar principles operate when, although the claimant was not engaged in his or her own business prior to the injury, the claimant commences a business after the injury. Being in control of the business, the claimant determines what personal salary is paid. The claimant can, and will commonly, take no earnings at all, or very low earnings, out of the business when it is starting up in the expectation that he or she will reap the benefit later. Yet, the claimant may be doing a substantial amount of work which, under normal circumstances, would command a significant wage. In such a situation, the only way the Board can determine the claimant's real earnings is to estimate the value of the work the claimant does.

#35.30 Termination of Payments

Section 30(1) provides that payments for temporary partial disability continue so long as the disability lasts. This means that the benefits payable under this

section will be terminated when the worker's physical impairment resulting from the injury ceases to be temporary partial, i.e. it disappears entirely, becomes total or stabilizes. If the worker's impairment remains temporary, but is total, there will be entitlement to temporary total disability payments under Section 29(1) of the Act. If the impairment has stabilized, the worker will be entitled to be assessed for a permanent partial disability award. The principles to be followed in determining whether a condition has stabilized are set out in #34.54.

Benefits will be terminated under Section 30(1) where, notwithstanding the existence of a temporary partial physical impairment, the worker is suffering no loss of earnings as a result of the injury.

#35.40 Manner of Payment

Temporary partial disability payments are made in the same manner as temporary total disability payments. (8)

NOTES

(1) See #34.54
(2) S.29(2)
(3) See #34.40
(4) See #73.50; #78.00
(5) See #40.00
(6) See #67.20
(7) S.30(2)
(8) See#34.60

CHAPTER 6

PERMANENT DISABILITY AWARDS

#36.00 INTRODUCTION

Permanent disability awards are made when a worker fails to completely recover from an industrial injury or disease, but is left with a permanent residual disability. They commence at the point when the worker's temporary disability under the claim ceases and the condition stabilizes. They may be total (Section 22) or partial (Section 23).

Permanent disability awards are calculated on the basis of a worker's "average earnings". The computation of average earnings is dealt with in Chapter 9.

#37.00 PERMANENT TOTAL DISABILITY

Section 22(1) provides that "Where permanent total disability results from the injury, the compensation must be a periodic payment to the injured worker equal in amount to 75% of the worker's average earnings, and must be payable during the lifetime of the worker."

A pension is awarded to a worker which continues for life. Some examples of permanent total disability are paraplegia, quadriplegia, hemiplegia, total blindness, and severe loss of cerebral powers. Combinations of permanent partial physical impairments can also become permanent total disabilities, such as bilateral amputations of arms and legs.

#37.10 Commencement of Pension/Wage-Loss Payments Prior to Award

Permanently totally disabled workers are awarded pensions as soon as it is clear to the Board that they will survive their injuries.

From the date of the injury up to the date of the award, wage-loss payments are made at the same rate as the eventual pension. (Reference should be made to #66.20 regarding minimum policy in personal optional protection cases.) However, it may be necessary to make these payments at a provisional rate pending clarification of the worker's pre-injury earnings. (1)

#37.20 Minimum Amount of Compensation

Section22(2) provides that the compensation awarded for permanent total disability cannot be less per month than the minimum set out below. This minimum is subject to Consumer Price Index increases.

Date			$ Minimum
July 1, 2000	—	December 31, 2000	1,269.36
January 1, 2001	—	June 30, 2001	1,294.21
July 1, 2001	—	December 31, 2001	1,314.54
January 1, 2002	—	June 30, 2002	1,319.06

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

Section 33(5) provides that the compensation payable to workers who, on July 1, 1974, were in receipt of compensation for permanent total disability cannot be less than the amount set out above. This amount is subject to Consumer Price Index adjustments.

Where workers partially commuted their pensions prior to July 1, 1974, and are eligible for the increased minimum provided by Section 33(5), they do not simply receive a percentage increase on the benefits currently being received. The full amount of the increased minimum is paid, less the actual dollar amount that has been commuted. (2)

#37.21 Dual System of Measuring Disability

The statutory minimum only applies in cases where a worker is found to be 100% disabled on a physical impairment basis. It does not apply when the percentage of disability on a physical impairment basis is less than 100% but the worker is found to be totally unemployable under the dual system of measuring disability. (3)

#37.30 Manner of Payment

A monthly pension is awarded which is paid by cheque or, if the worker elects, by electronic direct bank deposit, at the end of each month. The same procedures apply as in the case of permanent partial disability awards. These are set out in #41.00.

#37.40 Reopening Claims

Where a claim involving a permanent total disability is reopened, no payments of wage loss can be made. Wage loss may, however, be payable where a claimant

receiving a permanent total disability pension of less than the current maximum suffers a new injury at work. The amount payable would be the difference between the pension being paid on the old claim and 75% of the wage rate on the new claim, limited by the current maximum.

#38.00 PERMANENT PARTIAL DISABILITY

The Board has two basic methods of assessing permanent partial disabilities. These are:

1. Loss of function/physical impairment method.
2. The projected loss of earnings method.

The use of these two methods is termed the "Dual System". These two methods are considered in every case where applicable, the amount of the pension being the higher of the two figures produced by the two methods.

#38.10 Decision-Making Procedure

The Disability Awards Officer or Adjudicator in Disability Awards is responsible for seeing that the necessary examinations and other investigations are carried out with respect to the physical impairment assessment and they make the decision on the degree of disability and whether a pension should be awarded.

Permanent functional impairment evaluations will be conducted by either a Disability Awards Medical Advisor or a Board authorized External Service Provider. The Rehabilitation & Compensation Services Division sets protocols and procedures for these evaluations. The Board determines whether the evaluation is referred to a Disability Awards Medical Advisor or an External Service Provider based on the nature of the injury and other relevant criteria as set out in the protocols.

The determination of whether there is a permanent psychological impairment, and the severity of the impairment, is made by either a Board Psychologist or a Board authorized External Service Provider. Once this evaluation is completed, the claim is referred to the Psychological Disability Committee to assess the percentage of disability resulting from the permanent psychological impairment. The Disability Awards Officer or Adjudicator assesses any percentage of disability for physical impairment and, in conjunction with the Committee's percentage of psychological disability, decides the worker's permanent disability award under the loss of function method.

The Disability Awards Committee is ultimately responsible for the conclusion on projected loss of earnings awards implemented under section 23(3) of the *Act*. The Disability Awards Officer or Adjudicator is required to conduct the necessary investigations and make a specific recommendation to the committee. It is the

function of the committee, following any further investigation it considers necessary, to agree or disagree with the Disability Awards Officer's or Adjudicator's recommendation. If the committee agrees, the Disability Awards Officer or Adjudicator will establish a pension according to the initial recommendation. If the committee disagrees with the Disability Awards Officer's or Adjudicator's recommendation, it will either establish an award which it deems appropriate to the circumstances or return the file for further investigation. The Disability Awards Committee consists of one senior representative from the Disability Awards, Medical, and Vocational Rehabilitation Services Departments.

Physical impairment and projected loss of earnings assessments are made at the same time. It is not proper to establish a physical impairment pension alone and delay a projected loss of earnings assessment on the grounds that it is difficult at the time to assess the claimant's potential loss of earnings. An assessment must be made, however great the difficulty. A decision may be reopened where a ground for reopening is met (see Chapter 14).

The rules of evidence followed by Disability Awards Officers, Adjudicators and the Disability Awards Committee are discussed in policy item #97.40.

EFFECTIVE: March 3, 2003 (as to reference to reopening and deletion of references to pension review and appeals)
APPLICATION: Not applicable.

#39.00 LOSS OF FUNCTION/PHYSICAL IMPAIRMENT ASSESSMENT

Section 23(1) provides that "Where permanent partial disability results from the injury, the impairment of earning capacity must be estimated from the nature and degree of the injury, and the compensation must be a periodic payment to the injured worker of a sum equal to 75% of the estimated loss of average earnings resulting from the impairment, and must be payable during the lifetime of the worker or in another manner the board determines."

The physical impairment method is the primary one used for measuring permanent disabilities. It is the method provided for in Section 23(1). In applying this method, the Board does not normally have regard to the individual worker's actual loss of earnings. It considers the physical and/or psychological condition of the worker. It results in a percentage of disability being allocated to the claimant's condition.

Once the percentage of disability is determined, it is applied to the worker's average earnings, and the pension is 75% of the amount so determined. For

instance, consider a worker with a 30% disability with average earnings of $3,400.00 per month:

	30% of 3,400.00	1,020.00
Monthly pension	75% of 1,020.00	765.00

There are two basic methods for assessing the percentage of disability. These are the Scheduled method and the Non-Scheduled method.

Where a claim is reopened more than three years after the injury and a worker has a compensable permanent disability or an increased permanent disability, but is unemployed at the time of the reopening otherwise than through the effects of the injury, and it is determined that the worker has no potential loss of earnings, a pension will be assessed on a physical impairment basis under Section 23(1) of the *Workers Compensation Act*. It will be calculated on the basis of the wage rate originally set on the claim subject to any appropriate wage rate review being carried out or Consumer Price Index adjustments.

#39.01 Chronic Pain

This policy sets out guidelines for the assessment of section 23(1) awards for workers who experience disproportionate disabling chronic pain as a compensable consequence of a physical or psychological work injury.

1. Definitions:

Chronic pain is defined as pain that persists six months after an injury and beyond the usual recovery time of a comparable injury.

The Board distinguishes between two types of chronic pain symptoms:

> Specific chronic pain - pain with clear medical causation or reason, such as pain that is associated with a permanent partial or total physical or psychological disability.
>
> Non-specific chronic pain - pain that exists without clear medical causation or reason. Non-specific pain is pain that continues following the recovery of a work injury.

2. Multidisciplinary Assessment:

Where a worker has been referred for a permanent partial disability assessment under section 23(1) for chronic pain, the Board officer in Disability Awards may refer the worker for a multidisciplinary assessment. (See policy item #22.35, “Pain and Chronic Pain”)

A multidisciplinary assessment may involve consideration of the worker's medical history, health status, the impact of the pain on the worker's physical functioning, psychological state, behaviour, ability to perform the pre-injury occupation and ability to perform activities of daily living. [See policy item #22.35, "Pain and Chronic Pain", subsection 2(b)]

Based on the various assessments, the evaluation will provide the Board officer with information on whether the worker is experiencing persistent chronic pain as a result of a work injury or disease and the extent of the chronic pain. The evaluation will also provide information on the consistency of the worker's pain presentations.

3. Evidence Considered in a Chronic Pain Section 23(1) Assessment:

In making a determination under section 23(1), the Disability Awards Officer or Adjudicator in Disability Awards will enquire carefully into all of the circumstances of a worker's chronic pain resulting from a compensable injury or disease.

The evidence that a Board officer may consider in a section 23(1) assessment for chronic pain includes the following:

i) The findings of any multidisciplinary assessments.

ii) Information provided by the worker's attending physician as well as any other relevant medical information on the claim.

iii) The worker's own statements regarding the nature and extent of the pain.

iv) The worker's conduct and activities and whether they are consistent with the pain complaints.

v) In cases of specific chronic pain, the Board officer will consider the extent of the associated physical or psychological permanent impairment and whether the specific chronic pain is in keeping with the particular permanent impairment.

The evidence that is relied upon to support the assessment of a section 23(1) award must be fully documented.

4. Entitlement to a Section 23(1) Assessment:

Entitlement to a section 23(1) award for chronic pain may only be considered after all appropriate medical treatment and rehabilitation interventions have been concluded.

(a) Specific Chronic Pain – Consistent with the Impairment

Where a worker has specific chronic pain that is consistent with the associated compensable physical or psychological permanent impairment, the section 23(1) award will be considered to appropriately compensate the worker for the impact of the chronic pain. Pain is considered to be consistent with the associated compensable impairment where the pain is limited to the area of the impairment, or medical evidence indicates that the pain is an anticipated consequence of the physical or psychological impairment. In these cases, an additional award for the specific chronic pain will not be provided, as it would result in the worker being compensated twice for the impact of the pain.

(b) Specific and Non-Specific Chronic Pain – Disproportionate to the Impairment

A worker's entitlement to a section 23(1) award for chronic pain will be considered in the following cases:

i) Where a worker experiences specific chronic pain that is disproportionate to the associated objective physical or psychological impairment.

Pain is considered to be disproportionate where it is generalized rather than limited to the area of the impairment or the extent of the pain is greater than that expected from the impairment.

In these cases, a separate section 23(1) award for chronic pain may be considered in addition to the award for objective permanent impairment.

ii) Where a worker experiences disproportionate non-specific chronic pain as a compensable consequence of a work injury or disease.

Disproportionate pain, for the purposes of this policy, is pain that is significantly greater than what would be reasonably expected given the type and nature of injury or disease.

Where a Board officer determines that a worker is entitled to a section 23(1) award for chronic pain in the above noted situations, an award equal to 2.5% of total disability will be granted to the worker.

EFFECTIVE DATE: January 1, 2003
APPLICATION: Applies to new claims received and all active claims that are currently awaiting an initial adjudication.

#39.10 Scheduled Awards *Permanent Disability Evaluation Schedule*

For all section 23(1) assessments and reassessments undertaken with reference to the *Permanent Disability Evaluation Schedule* on or after August 1, 2003, please refer to the *Permanent Disability Evaluation Schedule* in Appendix 4 of Volume II and the appropriate policies in Chapter 6 of Volume II on the application of the *Schedule*.

Scheduled awards are awards made under the Permanent Disability Evaluation Schedule, which is set out in Appendix 4. This is a rating schedule of percentages of impairment for specific injuries or mutilations. (4)

The Permanent Disability Evaluation Schedule is a set of guide-rules, not a set of fixed rules. The Disability Awards Officer or Adjudicator in Disability Awards is still free to apply other variables in arriving at a final pension; but the "other variables" referred to means other variables relating to the degree of physical impairment, not other variables relating to social or economic factors, nor rules (including schedules and guide-rules) established in other jurisdictions. In particular, the actual or projected loss of earnings of a worker because of the disability is not a variable which can be considered. (5)

Any revision of the schedule must be undertaken by procedures that are appropriate to changes of a legislative nature. It will not be done through appeal decisions in individual cases. The schedules in use in other jurisdictions are part of the material that would be looked at in any revision of the schedule used here; but they are not part of the material relevant in the decision of any individual claim.

In cases where the specific impairment is not covered by the schedule, but the part of the body in question is covered, the Disability Awards Officer or Adjudicator must first determine the percentage loss of function in the damaged area. This determination is based on the findings of the permanent functional impairment evaluation and other medical and non-medical evidence available. The final award is arrived at by taking this percentage of the percentage allocated in the schedule to the disabled part of the body. Because the schedule is used in the calculation, this type of award is still considered as a scheduled one. For example, the amputation of an arm down to the proximal third of the humerus or its disarticulation at the shoulder is scheduled at 70% of total disability. Suppose a worker suffers a severe crush injury to the arm which culminates in a permanent loss of half its function. The final assessment would be 50% of 70%, i.e. 35% of total disability.

#39.11 Age Adaptability Factor

The percentage rate derived by use of the simple physical impairment method is modified by the application of an age variable. This age adaptability factor is used for claimants over the age of 45 where the disability is calculated in accordance with the schedule. The disability is increased by 1% of the assessed disability for each year over 45 up to a maximum of 20% of the assessed disability.

Example:

Award effective at age 55
Scheduled disability 50% of total disability
Age adaptability factor 10% of 50% = 5% of total disability
Disability assessed at 55% of total disability

The worker's age at the effective date of the disability award is used, not his or her age at the time of the injury.

The age adaptability factor is not applied to non-scheduled awards. However, the worker's age is one of the overall considerations in making the judgment.

The age adaptability factor set out above has only been applied since October 2, 1958. Awards made prior to that date were subject to differing rules.

#39.12 Enhancement

For all section 23(1) assessments and reassessments undertaken with reference to the *Permanent Disability Evaluation Schedule* on or after August 1, 2003, please refer to the *Permanent Disability Evaluation Schedule* in Appendix 4 of Volume II and the appropriate policies in Chapter 6 of Volume II on the application of the *Schedule*.

The combined effect of two separate disabilities may be greater than the separate effect of each. Therefore, where a worker has an additional disability which pre-existed the injury or the injury causes more than one disability, the Board may, in certain situations, increase the overall percentage of disability that would otherwise be awarded. This is known as the "enhancement factor".

One situation where this may be done is where the worker has impairment in both arms or both legs. An enhancement factor of 50% of the lesser disability may be added to the total of the percentages awarded for each separate disability. Suppose, for example, a worker suffers an injury causing total immobility in the right ankle. That would be assessed pursuant to the schedule at 12% of total disability. There may be an adjustment for age; but suppose it appeared that, at the time of the work injury, the worker was already suffering from a serious disability involving total immobility in the left knee. The Disability Awards Officer or Adjudicator in Disability Awards may well conclude that having regard to the impaired mobility that the worker was already suffering through the disability in the left leg, the compensable disability in the right ankle results in a greater degree of physical impairment than it would for a person with a normal left leg.

Enhancement factors applied where more than one finger of the same hand is affected are dealt with in #39.22-32.

Prior to October 27, 1977, the Board did not normally permit an enhancement factor in respect of spinal column disabilities. However, subsequent to that date, the Board has concluded that such a factor may be added for combinations of disabilities when one of those disabilities involves the spinal column and that disability is shown to have been enhanced by the others. A factor of 50% of the disability attributed to the spine is added. Therefore, if the disability in the back is 10%, and the sum of the other disabilities is 16%, the enhancement factor is 5% and the total disability awarded 31%. This has not been retroactively applied to awards made prior to October 27, 1977.

#39.13 Devaluation

For all section 23(1) assessments and reassessments undertaken with reference to the *Permanent Disability Evaluation Schedule* on or after August 1, 2003, please refer to the *Permanent Disability Evaluation Schedule* in Appendix 4 of Volume II and the appropriate policies in Chapter 6 of Volume II on the application of the *Schedule*.

The percentages set out in the Permanent Disability Evaluation Schedule represent the loss occurring when a disability exists alone in an otherwise healthy limb or body. When a disability exists alongside another disability in the same or another part of the body, adjustments may have to be made. This adjustment may be in an upward direction. For instance, as indicated in #39.12, an enhancement factor may be added in certain cases when the combined effect of two disabilities in different areas of the body exceeds the sum of the schedule percentages allocated to each disability. On the other hand, where the sum of the schedule percentages allocated to several disabilities exceeds their actual combined effect, a downward adjustment is required. This is known as “devaluation”.

If the schedule provides that the total loss of a particular part of the body causes a certain percentage loss of future earning capacity, then a partial loss of the use of that particular part will leave only a portion of the function of that part of the body remaining. If the schedule allocates 70% to the amputation of an arm at the shoulder, the occurrence of a fused index finger and thumb, worth 18%, will leave only 52% of the value of the arm. Any subsequent disabilities will be measured by reference to the remaining percentage, not the whole percentage set out in the schedule, i.e. 52% rather than 70% in the above example. Therefore, if, following the fused index finger and thumb, the claimant suffers a fused elbow, and then a frozen shoulder, the relevant percentages of disability awarded will be as follows:

A.	Value of whole arm in schedule	70% of total
B.	Value of fused index finger and thumb in schedule	18% disability

C.	Remaining value of arm (A-B)	52%
D.	Value of fused elbow in schedule	20%
E.	Percentage awarded for fused elbow ($\frac{D}{A}$ x C)	14.9%
F.	Remaining value of arm (C-E)	37.1%
G.	Value of frozen shoulder in schedule	35%
H.	Percentage awarded for frozen shoulder ($\frac{G}{A}$ x F)	18.6%
I.	Total percentage of disability awarded (B + E + H)	51.5%

A claimant will never receive more than 70% for disabilities existing in one arm.

#39.20 Amputations of Arms or Legs

In assigning a rating level to any amputation, it must be assumed that the stump is structurally perfect, that it is well padded, that the scar is properly placed and that there is no undue tenderness on areas which are subject to pressure. Uncorrectable defects such as scarring, tenderness, grafts, muscle wasting, nerve damage may warrant a rating level higher than the schedule. In the case of major limb amputations, rating levels assigned should have regard to the type and probable usefulness of the prosthesis to which they are adaptable. Amputations always involve scheduled awards.

Where a worker suffers a permanent disability to the dominant hand, the fact the worker is unaccustomed to using the other hand to the same extent does not affect the percentage of measured disability. It is usually a temporary handicap rather than a permanent problem. Whether the worker was left- or right-handed is, therefore, not a relevant factor in establishing a pension for a permanent partial disability. It is, however, a factor that may sometimes be relevant in establishing temporary benefits, or in the provision of rehabilitation services. For example, it might be relevant in deciding exactly when the worker is fit to return to work, whether more exercise is needed, or whether retraining may be needed.

#39.21 Amputation of One Finger

For all section 23(1) assessments and reassessments undertaken with reference to the *Permanent Disability Evaluation Schedule* on or after August 1, 2003, please refer to the *Permanent Disability Evaluation Schedule* in Appendix 4 of Volume II and the appropriate policies in Chapter 6 of Volume II on the application of the *Schedule*.

It is usually considered that there must be shortening of the bone before an award is granted for finger amputations.

The percentages of disability awarded in respect of amputations of the fingers are set out in the Permanent Disability Evaluation Schedule (items 13 to 40).

In considering the index and middle fingers, if the amputation of the portion of the distal phalanx involves:

(a) less than 1/4 of the phalanx, it is not normally considered significant enough to have any impact on future earning capacity.

(b) 1/4 to 3/4 of the phalanx, it is considered as an amputation equivalent to 1/2 the value of the whole phalanx.

(c) 3/4 of the phalanx or greater, it is considered as an amputation equivalent to the whole phalanx.

In considering the ring and little fingers, if the amputation of the portion of the distal phalanx involves:

(a) less than 1/2 of the phalanx, it is not normally considered significant enough to have any impact on future earning capacity.

(b) 1/2 to 3/4 of the phalanx, it is considered as an amputation equivalent to 1/2 of the value of the whole phalanx.

(c) 3/4 of the phalanx or greater, it is considered as an amputation equivalent to the whole phalanx.

These are guidelines and discretion can be used in this area. For example, it is possible that with a loss of less than 1/2 of the distal phalanx of the ring finger there may be scarring and sensitivity remaining. Discretion could then be exercised because of the additional disabilities and an award considered.

#39.22 Amputation of More than One Finger

For all section 23(1) assessments and reassessments undertaken with reference to the *Permanent Disability Evaluation Schedule* on or after August 1, 2003, please refer to the *Permanent Disability Evaluation Schedule* in Appendix 4 of Volume II and the appropriate policies in Chapter 6 of Volume II on the application of the *Schedule*.

Enhancement factors for multiple finger disabilities are built into the hand charts, in the Permanent Disability Evaluation Schedule. To determine what chart or combinations of charts apply to particular multiple finger disabilities, the following procedure is used.

1. Determine the most distal component(s) of the finger(s) involved. Use the applicable chart and record the percentage of disability.

2. Follow this procedure for each next level involved.

3. Total the percentages from each common level to determine the overall percentage of disability.

Examples Using the *Permanent Disability Evaluation Schedule*

1. Index finger amputated at M.P. joint, middle finger amputated at D.I.P. joint.

   Take Chart #2

distal phalanx of index	1.4%
distal phalanx of middle	1.4%

   Take Chart #1

middle phalanx of index	1.6%
proximal phalanx of index	1.6%
Overall Award	6.0%

2. Index finger amputated at M.P. joint, middle finger at P.I.P. joint, and ring finger at D.I.P. joint.

   Take Chart #8

distal phalanx of index	1.7%
distal phalanx of middle	1.7%
distal phalanx of ring	1.0%

   Take Chart #2

middle phalanx of index	2.8%
middle phalanx of middle	2.8%

   Take Chart #1

proximal phalanx of index	1.6%
Overall Award	11.6%

#39.23 Amputation of Thumb

For all section 23(1) assessments and reassessments undertaken with reference to the *Permanent Disability Evaluation Schedule* on or after August 1, 2003, please refer to the *Permanent Disability Evaluation Schedule* in Appendix 4 of Volume II and the appropriate policies in Chapter 6 of Volume II on the application of the *Schedule*.

Partial amputation of the phalanx of a thumb is considered in the following fractions: 1/4, 1/3, 1/2, 2/3, 3/4. For example, if a worker suffered an amputation of the thumb involving 2/3 of the distal phalanx, an award of 2/3 of 4% or 2.67% would be considered.

#39.24 Amputation of Thumb and One or More Fingers

For all section 23(1) assessments and reassessments undertaken with reference to the *Permanent Disability Evaluation Schedule* on or after August 1, 2003, please refer to the *Permanent Disability Evaluation Schedule* in Appendix 4 of Volume II and the appropriate policies in Chapter 6 of Volume II on the application of the *Schedule*.

The percentage of disability of the thumb is determined and the percentage of disability for the finger or fingers is determined. Normally, an enhancement factor of 100% of the lesser of these two disabilities is then added. The Disability Awards Officer or Adjudicator in Disability Awards does have discretion, based on the severity of the injuries, to adjust the enhancement factor, but normally a 100% multiple of the lesser is used.

More serious disabilities of this type are awards listed in the Permanent Disability Evaluation Schedule, items 9-12.

#39.30 Restrictions of Movement in Arms or Legs

For all section 23(1) assessments and reassessments undertaken with reference to the *Permanent Disability Evaluation Schedule* on or after August 1, 2003, please refer to the *Permanent Disability Evaluation Schedule* in Appendix 4 of Volume II and the appropriate policies in Chapter 6 of Volume II on the application of the *Schedule*.

Restrictions of movement in the joints of the body are measured and documented during the permanent functional impairment evaluation. The Disability Awards Officer or Adjudicator in Disability Awards then applies the measurement to the appropriate item in the Permanent Disability Evaluation Schedule.

These awards are always scheduled.

#39.31 Finger Restrictions

For all section 23(1) assessments and reassessments undertaken with reference to the *Permanent Disability Evaluation Schedule* on or after August 1, 2003, please refer to the *Permanent Disability Evaluation Schedule* in Appendix 4 of Volume II and the appropriate policies in Chapter 6 of Volume II on the application of the *Schedule*.

When considering restriction of finger movement, the full range of flexion restriction is taken into consideration, but only 50% of the range of restricted extension. This is because extension is not considered as vital as flexion. The formula used to compute a percentage value for restriction of finger movement is:

$$\frac{\text{Restriction Degrees}}{\text{Normal Degrees}} \times 3/4 \times \text{amputation value at the joint concerned}$$

This formula is used as it is normally considered that a fused finger joint is equal to 3/4 of the value of an amputation at the same level.

Items #51, #52 and #53 of the Permanent Disability Evaluation Schedule allow a higher value to be applied if necessary (up to value of amputation). These are normally used when the fused finger is essentially useless and there would be no difference in the disability if the finger had been amputated.

When more than one finger is involved, the appropriate multiple finger chart from the Permanent Disability Evaluation Schedule is used to determine the amputation value at the joint concerned, thus building in any enhancement factor.

#39.32 Thumb Restrictions

For all section 23(1) assessments and reassessments undertaken with reference to the *Permanent Disability Evaluation Schedule* on or after August 1, 2003, please refer to the *Permanent Disability Evaluation Schedule* in Appendix 4 of Volume II and the appropriate policies in Chapter 6 of Volume II on the application of the *Schedule*.

The basic principles set out in #39.31 also apply here. The formula used to compute a percentage value for restriction of thumb movement is:

$$\frac{\text{Restriction Degrees}}{\text{Normal Degrees}} \times 1/2 \times \text{amputation value at the joint concerned}$$

This formula is used in that it is normally considered that a fused thumb joint is equal to 1/2 of the value of an amputation at the same level.

Where a finger and thumb are affected, an enhancement factor is added in the manner set out in #39.24.

#39.40 Sensory Losses

For all section 23(1) assessments and reassessments undertaken with reference to the *Permanent Disability Evaluation Schedule* on or after August 1, 2003, please refer to the *Permanent Disability Evaluation Schedule* in Appendix 4 of Volume II and the appropriate policies in Chapter 6 of Volume II on the application of the *Schedule*.

Some sensory losses are specifically listed in the Permanent Disability Evaluation Schedule. Others, though not specifically referred to, may be assessed on a judgment basis as part of the overall disability incurred in a part of the body covered in the schedule.

The complete loss of the major nerves in the arms and legs is covered in items 73 to 76 of the Permanent Disability Evaluation Schedule.

When the fingers lose sensitivity as the result of an injury, an award of up to the full amputated value of the joint can be granted. This especially relates to the thumb, index and middle fingers, when the pinch grip is involved.

Awards for hearing loss are dealt with in #31.00.

#39.41 Loss of Taste and/or Smell

Although there is not a scheduled award for the loss of either or both of these senses, the Board's policy is to allow 3% for a loss of smell. This includes the partial loss of taste, which always in practice accompanies a complete loss of smell. A loss of taste alone is regarded as a non-scheduled award.

If the loss of sense of taste or smell results from an occupational disease, the requirements of Section 6 must be met before a pension can be awarded, including the requirement that there be a disablement from earning full wages. (6)

#39.42 Visual Acuity

For pension purposes, loss of visual acuity should be measured both before and, if correction is possible, after correction with conventional lenses. The intent of this evaluation is to determine the nature and degree of the injury.

Section 23(1) of the Workers Compensation Act provides compensation based on the existence of a permanent partial "disability". The degree of disability is the extent to which the injury is presumed to impair the earning capacity of the average worker. In determining the degree of disability for the purposes of calculating an award under Section 23(1), measurement of the loss of visual acuity is usually based on the best vision obtainable after correction with conventional lenses. Effective application of corrective lenses should eliminate any impairment of earning capacity.

The Permanent Disability Evaluation Schedule, items 84 to 90, sets out the percentages of disability payable for loss of visual acuity. These values have been developed based on corrected vision in order to establish an accurate measure of disability.

The Board recognizes that certain occupations require perfect uncorrected vision as a condition of employment. A worker who was employed in such an occupation prior to the injury may suffer an actual loss of earnings. In these circumstances, it may be more equitable to provide compensation under Section 23(3). A Section 23(3) pension is calculated by determining the difference between the average earnings of the worker before the injury and the average amount the worker is able to earn in some suitable occupation after the injury.

As total blindness in one eye is assessed at 16% of total and total blindness in two eyes is equal to 100% of total disability, the value attached to the total loss of the second eye is 84%. When assessing a bilateral visual loss which is less than total, each eye is first assessed separately in accordance with the schedule. 84/16 times the percentage applied to the better eye is then added to the percentage applied to the poorer eye.

Where the work injury leaves the worker with an aphakic eye, an award of 12% of total is made. This award is on the assumption that the worker has 20/20 vision. If the vision is worse, the worker receives an additional award equal to the percentage allocated in the schedule to the loss of visual acuity, but this additional award is devalued according to the rules set out in #39.13. If, for example, a worker with an aphakic eye has 20/60 vision the percentage is calculated as follows:

A.	Percentage for blind eye	16%
B.	Percentage for aphakic eye	12%
C.	Percentage for loss of visual acuity equal to 20/60 (Item 87 in schedule)	4%
D.	Additional percentage awarded where B combined with C 4% (C) 16% (A) X [16%(A) – 12%(B)]	1%
E.	Total percentage awarded [(B) + (D)]	13%

The above formula would also apply in other situations where a compensable eye disease is combined with a loss of visual acuity.

#39.43 Sexual and Reproductive Function

Sexual function is defined as the ability to engage in sexual activity. It must be distinguished from reproductive function, which is defined as the ability to procreate.

Cases involving sexual or reproductive function are classified as follows:

1. Impaired sexual or reproductive function resulting from paraplegia, quadriplegia, or similar disabilities.

   In these cases, the worker is generally receiving an award for total disability, and where that is so, there is no scope for considering impaired sexual or reproductive function as a separate compensable item.

2. Where a physical injury other than to the genital organs or their related structures results in a psychological disturbance, and impaired sexual function is a symptom or consequence of the psychological disorder.

   In this situation, the psychological problem, including the impaired sexual function, should be considered according to the principles applicable to psychological problems, and the impaired sexual function should not be considered as a separate matter. In cases of this kind, it is normal to explore the possibilities of treatment before regarding the case as one for a permanent disability award.

3. Where a compensable injury or occupational disease has caused permanent damage to the genital organs or related structures resulting in impaired sexual or reproductive function.

   The reference here is to cases where the remedial treatment has been considered and found not to be possible. Where impaired sexual or reproductive function in this category occurs, a permanent disability award will be given. The *American Medical Association Guide to the Evaluation of Permanent Impairment* will be used to determine the appropriate percentage of disability.

A worker with impaired sexual or reproductive function derived from physical damage to the sexual or reproductive organs or related structures may suffer actual psychological symptoms over and above what might normally be assumed for impaired sexual or reproductive function. In such a case, it will not be appropriate to simply grant an award which is based on the ordinary assumed psychological effect. An assessment of the actual psychological disability suffered by the worker should be carried out in accordance with the general policy for assessing such disabilities under Section 23(1) of the Act. If, after that assessment, it is found that the worker is entitled to a general psychological award of an amount higher than what might normally be awarded for impaired sexual or reproductive function, the worker will be paid this award in lieu of the award for impaired sexual or reproductive function.

With regard to impairment of sexual function, this policy applies to impairments occurring on or after April 6, 1992. For impairments occurring prior to that date, the policy was to use a table of percentages of disability for an impairment resulting from physical damage to the genital organs. The percentage varied

according to the age of the worker. There was a maximum of 15% for a worker aged 45 at the time of injury reducing to 5% for a worker aged 65 or over. The table of percentages did not apply to an impairment of sexual function resulting from paraplegia, quadriplegia or similar disabilities, to impairment of sexual function resulting from psychological causes, to female workers or to impairment of reproductive function. Awards in these situations were considered separately. (7)

With regard to impairment of reproductive function, this policy applies to impairments occurring on or after April 6, 1992 as well as to existing impairments in respect of which a request for an award is subsequently submitted to the Board. However, no payments under this policy will be made in respect of the time period prior to April 6, 1992.

#39.44 Assessment of Pensions for Hand-Arm Vibration Syndrome

To measure the extent of any permanent disability resulting from Hand-Arm Vibration Syndrome, the evaluation is carried out in the following manner:

1. The Disability Awards Medical Advisor assesses the vascular, sensorineural and musculoskeletal impairments of the worker in reference to the following table.

ELEMENTS	Process (Assess each hand separately)	Points Applied
Vascular Element:	Assess vascular elements: blanching of fingers in cold temperature, pain, swelling, ulcers, gangrene & amputations: • Distal phalange on index, middle and ring finger = 1 point each • Middle phalange on index, middle and ring finger = 1 point each • Proximal phalange on index, middle and ring finger = 2 points each • All phalanges on little finger = 1 point • All phalanges on thumb finger = 1 point • Distal half of palm (top) = 1 to 2 points • Proximal half of palm (bottom) = 1 point	17 points max per hand
	ADD: Double value of sum of above if there is evidence of trophic changes (i.e., ulcers)	17 points max per hand
	MAXIMUM points for Vascular element	34 points per hand

Sensorineural Element:	Assess sensorineural impairment (evidence of numbness, tingling and reduced sensory perception)	2 points max per hand
	Assess manual dexterity (i.e., difficulty with buttons and writing) • Additional 1 to 2 points per hand if reduction occurs	2 points max per hand
	MAXIMUM points for sensorineural element	4 points per hand
Musculoskeletal Element:	Assess musculoskeletal impairment (loss of grip strength)	2 points max per hand
	MAXIMUM points from vascular, sensorineural and musculoskeletal elements for each hand	40 points per hand
	Add total points for both hands.	

2. The Board Officer in Disability Awards assesses the worker's disability using the Disability Awards Medical Advisor's assessment of impairment and the following table.

Conversion of Points to Percentages of Disability

Points System	**% Disability**	**Points System**	**% Disability**	**Points System**	**% Disability**
1 – 4	1	21 – 30	6	Beyond 40	Maximum of 20
5 - 15	2	31 – 35	8		
16 - 20	4	36 – 40	10		

Where the Board Officer in Disability Awards considers it more equitable, section 23(3) of the *Workers Compensation Act* will apply in the assessment of pensions for Hand-Arm Vibration Syndrome.

EFFECTIVE DATE: November 19, 2002
APPLICATION: To all section 23(1) decisions adjudicated after the effective date.

#39.50 Non-Scheduled Awards

Any award where the schedule is not directly or indirectly used in the assessment is a non-scheduled award. This covers impairments in all parts of the body not listed in the schedule. Disabilities resulting from multiple injuries or occupational diseases may also involve non-scheduled awards. The rules governing respiratory and skin diseases are set out in #29.00 and #30.50 respectively.

In the case of non-scheduled awards, the Disability Awards Officer or Adjudicator in Disability Awards use their own judgment to arrive at a percentage of disability appropriate to the particular claimant's impairment. Regard will be had to, inter alia, the permanent functional impairment evaluation, the circumstances of the claimant, medical opinions of Board or non-Board doctors, and to schedules of disability used in other jurisdictions.

Neither the age adaptability or enhancement factors nor devaluation are formally applied in respect of non-scheduled awards. (The exception is that an enhancement factor may be added with respect to spinal injuries as outlined in #39.12.) However, in making a judgment as to the correct percentage of disability, the Disability Awards Officer or Adjudicator will have regard to the age of the claimant, to existing disabilities in other parts of the claimant's body, or to the combined effect of more than one disability in the same part of the body.

#39.60 Minimum Pension

The minimum compensation for permanent partial disabilities is calculated in the same manner as for temporary total disability but only to the extent of the partial disability. (8) Thus, for example, if a worker is injured on January 2, 1986, and suffers a residual disability assessed at 10% of total disability, the minimum compensation will be the lesser of 10% of $197.25 or 10% of his average earnings prior to the injury. (The formula for converting this weekly figure to the monthly equivalent is contained in #68.00.)

The minimum for permanent total disability does not apply simply because a worker is found to be totally unemployable under Section 23(3). (9)

#39.61 Injury Prior to March 18, 1943

Notwithstanding any other provision of the Act, all periodic payments awarded as compensation for permanent partial disability to workers injured prior to March 18, 1943, who, on January 1, 1955, or after that are in receipt of those periodical payments are calculated or recalculated at a rate of sixty-six and two-thirds per cent of average earnings of not less than two thousand dollars nor more than two thousand five hundred dollars per annum. Compensation is not payable under this provision for any period prior to January 1, 1955. (10)

#39.62 Injury Prior to January 1, 1965

In regard to payments made on or after January 1, 1965, permanent partial disability pensions awarded in respect of injuries occurring before that date were recalculated in accordance with the then minimum for permanent total disability but to the extent only of the partial disability. This minimum was an amount equal to $30.00 per week ($130.00 per month), unless the worker's average earnings were less, in which case compensation would be paid in an amount equal to the average earnings.

Any increase resulting from the above provisions did not apply to a commuted pension or the commuted portion of a pension.

In considering whether the worker's earnings were less than the minimum, the artificial wage created by the application of #39.61 was not taken into account. Only the worker's actual earnings were relevant.

#40.00 PROJECTED LOSS OF EARNINGS METHOD

Section 23(3) provides that "Where the board considers it more equitable, it may award compensation for permanent disability having regard to the difference between the average weekly earnings of the worker before the injury and the average amount which the worker is earning or is able to earn in some suitable occupation after the injury, and the compensation must be a periodic payment of 75% of the difference, and regard must be had to the worker's fitness to continue in the occupation in which the worker was injured or to adapt to some other suitable employment or business."

On October 2, 1973, the Board introduced a dual system for assessing permanent disability pensions involving the spinal column. Effective October 1, 1977, this system was extended to non-spinal injuries. This system implements Section 23(3) of the Act.

Under this system, awards are calculated as follows:

1. The degree of physical impairment is calculated using the method described in #39.00, and a possible pension is calculated in accordance with this.
2. A possible pension is calculated according to the projected loss of earnings method described in #40.10.
3. The higher of these two results is then used as the pension.

Where the claimant is aged 51 years or above, this system is modified in the manner set out in #40.20.

It is not the policy of the Board to grant an award under the dual system without regard to the nature of the condition or disability causing the unemployability or loss of earnings. The worker must not only have a disability accepted by the Board, but the disability accepted by the Board must be a significant factor in the reduced employability or loss of earnings potential. Therefore, the Board has declined to grant awards under the dual system when the unemployability of the worker is related directly to psychological problems which are not considered acceptable as part of the claim.

Where a Disability Awards Officer or Adjudicator in Disability Awards decides that no pension can be awarded on a physical impairment basis because the

impairment is unlikely to affect the worker's earning capacity, no pension can be awarded on a projected loss of earnings basis. While Section 23(3) is not expressed to be dependent on an award being made under Section 23(1), this must in practice be the case. The Board could not consistently decide at the same time both that a worker's impairment was too minimal to affect earning capacity and that it would cause a loss of earnings in the future.

The Board will not make a temporary award on a projected loss of earnings basis.

#40.10 Assessment Formula

The rules, set out in #40.10-#40.30 apply to assessments of new permanent disability awards carried out on or after April 18, 1985.

These rules do not apply to earlier projected loss of earnings awards unless those awards are reassessed on the basis of a change in the worker's physical impairment. Where, on such a reassessment, there is found to have been a deterioration in the worker's physical impairment and these rules produce a lower pension than the projected loss of earnings pension the worker is currently receiving, the current pension will remain unchanged. The pension will, however, continue to be adjusted in the normal way in accordance with changes in the Consumer Price Index.

Where a pension was calculated on the policies prior to April 18, 1985, and an appeal results in a reconsideration of the pension, the reconsideration will be carried out under the same rules that applied at the time the **original decision** was made.

The rules for assessing a projected loss of earnings pension under Section 23(3) adopted by the Board are:

1. Average earnings prior to the injury will be determined in accordance with established policies and procedures.

2. Having regard to the evidence, including the medical evidence, of the limitations imposed by the compensable disability and the fitness of the claimant for different types of work, and having regard to the evidence of the Rehabilitation Consultant about the suitability of the claimant for jobs that could reasonably become available, the Adjudicator in Disability Awards will arrive at a conclusion about suitable occupations that the claimant could be expected to undertake over the long-term future.

3. Earnings that maximize the claimant's long-term potential will be selected from the jobs that are suitable and reasonably available. Earnings in those occupations will be determined as at the time of the injury.

4. The possible pension will then be 75% of the amount by which the earnings level thus established is less than the average earnings prior to the injury.

5. Any increase that may be due to the claimant because of an increase in the Consumer Price Index will then be added.

6. Since the assessment on a projected loss of earnings basis aims to predict the worker's actual loss of earnings over the future, no award can be made when the worker is unemployed for reasons unrelated to the injury and it is determined that there will not be a potential loss of earnings.

It may be helpful to illustrate how the dual system works. Consider the example of a skilled tradesperson in a trade that involves manual labour earning an average of $3,500 per month. Assume, in 1985, the worker suffered a back injury as a result of being crushed under a load dropped from an overhead crane and had spinal surgery, following which the worker was unfit to return to the former occupation. Having regard to age and educational background, the worker is not considered suitable for retraining; but is able to take an unskilled clerical job and can now earn $2,150 per month. Average earnings in 1985 for that occupation would be approximately $1,900 per month. The pension is now being assessed in 1986. The way it might work out is as follows:

Method 1

Medical assessment estimates the degree of physical impairment, measured according to the physical impairment method, at 10% of total disability	10%
Average actual earnings prior to injury	$3,500.00 per month
Statutory ceiling applicable in 1985	$2,700.00 per month
Amount that would be payable for total disability (75% x $2,700.00)	$2,025.00 per month
Compensation payable as partial disability pension (10% of total disability)	$202.50 per month

Method 2

Actual average earnings in 1985	$3,500.00 per month
Statutory ceiling in 1985	$2,700.00 per month
Average earnings obtainable in unskilled clerical work in 1985	$1,900.00 per month

Compensable loss of projected earnings ($2,700.00 less $1,900.00)	$800.00 per month
75% thereof	$600.00 per month

Being entitled to the greater of the two amounts, the claimant will now receive a pension of $600.00 per month plus applicable Consumer Price Index increases.

#40.11 Average Earnings Prior to Injury

Further comment is required on items 1 to 3 in #40.10.

Section 23(3) of the *Workers Compensation Act* requires the Board to have regard to the "average weekly earnings of the worker before the injury". This is generally in line with the other sections of the Act which govern the payment of temporary or permanent disability benefits, namely Sections 22, 23(1), 29 and 30. All of these provisions base compensation on the worker's earnings, but use the slightly different term "average earnings".

It has been suggested that the use of the term "average weekly earnings" in Section 23(3), as opposed to the term "average earnings" is significant. This arises in relation to the provisions of Section 33(1) which give the Board a wide authority to determine the "average earnings and earning capacity of a worker", but place a limit on the earnings that can be used in the form of the maximum wage rate. It is contended that since it specifically refers to "average earnings", Section 33(1) is not relevant to determining "average weekly earnings" under Section 23(3) with the result that the maximum wage rate does not limit those earnings. Rather, the maximum limits only the ultimate pension that can be awarded under that section.

While noting the slight difference in terminology, Section 23(3) clearly requires the Board to determine a worker's earnings prior to the injury and Section 33 is the only section in the Act which provides for how this is to be done. The Board has concluded that "average weekly earnings" prior to the injury must be determined under the projected loss of earnings method in the same manner as "average earnings" are determined for the purpose of pensions assessed under Section 23(1) and the maximum wage rate must apply to limit those earnings.

The average earnings prior to the injury are calculated according to the normal rules set out in #68.00.

In making this calculation, regard will not normally be had to promotions which might have been received if the worker had not been injured. This is so even though the worker returns to the pre-injury job following the injury, is promoted, but is unable to remain in the job because of the disability.

When calculating the pre-injury earnings of a person covered by personal optional protection, a departure is made from the normal rule of using the rate of earnings for which coverage has been purchased. (11) For the purpose of the projected loss of earnings assessment, actual pre-injury earnings are used, but the amount of the award can never exceed the amount of earnings for which the coverage was purchased.

#40.12 Suitable and Available Occupations for the Claimant

The purpose of direction 2 in the assessment formula set out in #40.10 is to arrive at a long-term projection of the earning capacity of the worker. The evidence of the Rehabilitation Consultant should relate to jobs that are suitable and reasonably available to the claimant in the long run and the conclusion of the Adjudicator in Disability Awards should be concerned with such of those jobs as will maximize the claimant's long-term earnings potential.

It is not satisfactory simply to take the wage rate in a job to which the claimant actually returns. For a variety of reasons, the long-term employment prospects of a claimant may be different from the most immediate job opportunities. On the other hand, the phrase "available jobs" does not mean any job position in which there are vacancies. An available job means one reasonably available to the claimant in the long run. For example, a city may have several theatres, and there may be occasional job vacancies for the position of theatre usher; but if there are always numerous better qualified applicants and the realities are that a worker with the particular disability is not likely to obtain such a job, that is not a reasonably available job.

In advising on the suitability of the claimant for reasonably available jobs, the Rehabilitation Consultant must have regard to the limitations imposed by the residual compensable disabilities of the claimant and assess the claimant's earnings potential in light of all possible rehabilitation measures that might be of assistance, including the possibility of retraining or other measures that may be appropriate to the particular worker.

The guidelines set out below are followed in determining suitable and reasonably available jobs for a claimant:

1. Where the worker is doing his or her best to maximize earnings, and is following the advice of the Rehabilitation Consultant, and is presenting himself or herself in good faith to obtain a job at the highest level of earnings among the jobs that the worker is fit to undertake, then the earnings level in the job that is actually obtained is generally the earnings level that should be taken, unless there is evidence that this position is transitory and that jobs at another level of earnings will be available to the worker in the near future.

2. Regard may be had to other jobs than the present one with the same employer to which the worker might in future progress and this is not limited to jobs which the claimant has a right to because of seniority. The fact that there is a formal or informal competition for a higher job is not a bar to its being considered. On the other hand, it would not be fair to assume that a claimant will receive all possible promotions that might theoretically be open. The Board is only concerned with jobs that are, in practice, reasonably available. Thus, the Board will, in general, only have regard to higher paying jobs which a person in the claimant's present job would ordinarily be expected to obtain.

3. A reasonably available job must be one that the worker is fit to undertake, and which would not involve adverse health consequences either immediately or in the long run compared with other jobs.

4. Where a suitable job is reasonably available over the long term, it is taken into consideration even though it is not reasonably available at the time of assessment because of general economic conditions.

5. In deciding whether it is reasonable for a worker to refuse a job, regard should be had to the long term as well as the immediate position. For example, job A may have an earnings rate of $16.00 an hour, and job B may have an earnings rate of $15.00 an hour; but if job A is subject to fluctuations in the economy and job B appears more stable in the long run, then job B may be the better-paying job in the long run. Therefore, the wage rate in job B should be used in the calculation of projected loss of earnings.

6. A reasonably available job must be one that is within a reasonable commuting distance of the worker's home. Where there is no available job within that commuting distance that the worker could reasonably be expected to undertake, the worker might be expected to relocate, depending on age, the availability of a suitable job elsewhere, and other factors; but relocation will not normally be expected unless the worker is offered the expenses of relocation, either by the Canada Employment and Immigration Commission or by the Board or by some other government agency.

7. If the worker declines the best-paying reasonably available job because of a personal preference for a lower-paying occupation or for an alternative life-style, the wage rate in the best-paying reasonably available job should be used in the formula.

For the distinction between the jobs which can be considered properly available for the purpose of the projected loss of earnings method and those which can be considered as available for the purpose of assessing temporary partial disability benefits, reference should be made to #35.21.

#40.13 Measurement of Earnings Loss

Section 23(3) requires the Board to compare the average weekly earnings of the worker before the injury with "the average amount which the worker is earning or is able to earn in some suitable occupation after the injury". The latter figure is obtained by ascertaining the earnings in the occupations which have been found to be suitable and reasonably available according to the criteria set out in #40.12 and determining the earnings figure which will maximize the claimant's long-term earnings potential.

The intention of the Act is to protect workers' earnings only up to the maximum wage rate. This is shown by Section 33(1) which results in payments for total disability being limited to 75% of the maximum and by Section 31 which ensures that, where a worker is already receiving payments for a disability, additional payments can be made for any further disability only to the extent that they do not take the total payments above the maximum. No pension can be awarded on a projected loss of earnings basis where, following the injury, the claimant is earning or is able to earn at or above the maximum wage rate. Where a claimant was earning at or above the maximum prior to the injury and it is projected that because of the injury earnings will be less than the maximum, a projected loss of earnings pension can be awarded but only to the extent of the difference between the maximum and the projected earnings.

Although assessment of a pension will often be made some time after the original injury, it would not be fair to compare directly the actual pre-injury earnings with the earnings the worker might now earn in the jobs available. The effect of inflation upon earnings levels would mean that the real loss would not be properly determined in that way. The practice of the Board is to use the earnings in the jobs available after the injury as they stood at the date of the injury. It occasionally happens that earnings in jobs at the time of the injury are not available. If this occurs, it may be necessary to use the earnings in those jobs as they were at another date and bring the pre-injury earnings into line by applying Consumer Price Index adjustments.

#40.14 Provision of Employability Assessments

Workers are provided with a copy of a completed employability assessment before a pension decision is made. They have 30 days in which to provide a written submission. All such submissions received within this time frame will be considered before the final decision is made. Workers are also advised that, at their request, a copy will be made available to their treating physicians. If the details of the employability assessment and its impact on the pension are known and agreed to, the 30-day waiting period may be waived.

#40.20 Duration of Projected Loss of Earnings Pension

Pensions assessed on a physical impairment basis are, under the terms of section 23(1), payable for life. It was suggested that projected loss of earnings pensions should also be payable for life in every case, but the Board does not accept this. Section 23(3) does not specifically require this, but rather gives the Board a discretion in the matter. Compensation is only payable under section 23(3) "Where the board considers it more equitable". Since the section authorizes the Board to calculate a worker's actual loss of earnings resulting from the injury, it is reasonable for the Board to have authority to terminate benefits payable under the section at a time when, even if not disabled because of the compensable injury, the worker would not have been working.

The situation where this issue arises is when the worker reaches retirement age. The Board considers age 65 years to be the standard retirement age. Any direct loss of earnings the worker suffers because of the compensable disability will normally cease at that time. However, the Board does not, in practice, feel this is an automatic reason for terminating a projected loss of earnings pension. Rather, it is recognized because of the compensable disability, the worker may be less able to accumulate retirement benefits. The Board, therefore, allows the projected loss of earnings pension to continue in whole or part past the standard age of retirement where the worker was under 65 years of age at the time of the injury. The portion of the pension so continued depends on how close the worker was to the age of 65 years, the assumption being that the older the worker, the less the ability to build up retirement benefits would be affected by the injury.

The following principles apply:

1. Where, at the date of injury, the worker is at or below the age of 50 years, the pension is established based on the higher of the physical impairment and projected loss of earnings assessment, and the pension so established is payable for life.

2. Where, at the date of injury, the worker is at or above the age of 65 years, the pension will usually be established by the physical impairment method, and that pension is payable for life. No projected loss of earnings pension is awarded unless clear and objective evidence is presented that the worker would have continued to work past age 65 if the injury had not occurred. Where a projected loss of earnings pension is awarded, it will cease when the worker reaches retirement age, as determined by a Board officer, and compensation will thereafter be established by the physical impairment method.

3. Where, at the date of injury, the worker is in the age range of 51 to 64 years, and where a pension calculated by the projected loss of earnings method is payable, the pension so calculated, unless modified on a review, will usually continue until the age of 65 years. From the age of 65, the pension is at a rate calculated by the physical impairment method, plus a proportion of the difference between the two methods according to the following table.

Age at Date of Injury	Proportion of Difference Between Two Methods
51	14/15ths
52	13/15ths
53	12/15ths
54	11/15ths
55	10/15ths
56	9/15ths
57	8/15ths
58	7/15ths
59	6/15ths
60	5/15ths
61	4/15ths
62	3/15ths
63	2/15ths
64	1/15th

The revised pension commences on the first day of the month following the worker's 65th birthday.

Where the projected loss of earnings pension is assessed following a recurrence of disability, the age at the date of the recurrence is used for the purpose of the above principles.

In cases where the worker presents clear and objective evidence that he or she would have worked past age 65 if the injury had not occurred, the projected loss of earnings pension may continue in whole past that age. In these situations, the formula provided in the table above does not apply. From the age of retirement, as determined by a Board officer, compensation will be established by the physical impairment method.

4. Where an injury occurs in the age range 51-64 years, and full wage-loss payments are made from the date of injury up to or beyond the worker's 65th birthday, a pension will usually be established by the physical impairment method, and that pension will be payable for life.

A projected loss of earnings pension may be awarded if the worker presents clear and objective evidence that he or she would have worked past the standard retirement age had the injury not occurred. In these situations, the projected loss of earnings pension will cease when the worker reaches retirement age, as determined by a Board officer, and compensation will thereafter be established by the physical impairment method.

In calculating a worker's projected loss of earnings, no account is taken of any disability or retirement pensions received from the employer to which the worker has contributed or any other source than the Board. However, a Board officer may take into account the fact that the worker has retired or is about to retire in deciding whether there is a projected loss of earnings in the first place. The formula set out above only applies when it has been determined that there is such a loss and the pension is assessed on the basis of that loss.

EFFECTIVE DATE: March 3, 2003 (as to deletion of reference to pension review)
APPLICATION: Not applicable.

#40.31 Existing Pension Assessed Prior to Establishment of Dual System

Differing rules apply to spinal and non-spinal disabilities.

Upon any application for reopening of entitlement to pension benefits in the case of an injury involving the spinal column, the dual method of assessment is applied if the worker is under the age of 64 years and a pension has not previously been calculated or considered under the dual method. This applies regardless of the date of injury, but the effective date for any readjustment is the date of the application for reopening. Where the claimant was in receipt of a term pension that has expired or the claimant has commuted a life pension, the pension so expired or commuted is recalculated as a notional life amount. If the projected loss of earnings method produces a pension in excess of that notional life amount, a new pension will be instituted, but only to the extent of the excess.

Any pension for a non-spinal disability which has been assessed since October 1, 1977, on the basis of functional impairment only, and where the application of the dual system was not considered, will be reconsidered on that basis should such a request be made. Should an application be made for reopening of a pension assessed before October 1, 1977, on the basis of changed medical circumstances, and it is concluded that the application has merit and the pension should be reassessed, that reassessment will include consideration of a loss of earnings award as of the date of the changed medical condition but not retroactive to the date the pension was first established. In the case of applications for reconsideration on the basis of significant new evidence or error in law in the original decision, even if the new evidence or submission results in a change in the

original decision, no consideration can be given to a loss of earnings award unless, of course, the original decision was made since October 1, 1977. In other words, a simple request to reopen the claim on the basis that a claimant wishes to have a pension reassessment under the new system must be rejected on the ground that the "new system" is effective only from October 1, 1977 for non-spinal disability.

#41.00 PAYMENT OF PENSIONS

Pensions are normally payable monthly and last for life. However, some are paid as lump sums. The cheques are mailed to the claimant's home address or, if she or he elects, direct to their bank by electronic direct bank deposit.

When a payment to a worker has been lost or stolen or otherwise not received or cashed by the worker, the worker may request a reissue of payment, but the Board will require a written and signed declaration of this from the worker before a reissue will take place.

#41.10 Commencement of Pension

The general rule is that the pension commences at the date when the claimant's temporary disability ceased and his condition stabilized or was first considered to be permanent.

Where a worker has been paid any temporary disability benefits under Section 29 or 30 of the Act, the pension will take effect from the date following the termination of these temporary benefits. For the majority of cases, this will adequately reflect the financial impact of the disability on the worker's earnings.

There may, however, be the unusual situation where a worker has or could have returned to a significant level of employment with a minimal loss of income. Wage-loss benefits under Section 30 would be 75% of this minimal figure.

Should the worker eventually be assessed at a pension rate which is higher than the rate paid for temporary benefits under Section 30, it would appear that the worker may have suffered a loss of compensation income. The Act, however, precludes the payment of both temporary and permanent benefits for the same condition at the same time.

A problem of pension retroactivity also occurs when, although the worker had a temporary partial disability, the worker had or could have returned to full employment and has not, therefore, actually been paid any benefits under Section 30. As previously stated, the Act requires that the Board recognize a disability as either temporary or permanent, but not both concurrently. When carrying out the final disability assessment, the Officer in Disability Awards will have the benefit of the earlier examination, or at least some other documentary evidence on file, on which the decision was made to delay the pension. If the findings on the latter

examination are the same as the initial findings, or only show a minimal degree of change, it is reasonable to consider the condition as having plateaued from the date of the first examination. In that event, the date of the first examination should be the starting date of the pension. If, on the other hand, the latest examination shows a measurable and significant change since the first examination, the worker will be considered as having been, in the interim, temporarily disabled. In that event, the date of the last examination will be the starting date of the pension.

When there was no examination by either a Board Medical Advisor or an External Service Provider when wage-loss benefits were terminated under Section 30, and there is no other measurable data on file with which to make a comparison with the final assessment of the Officer in Disability Awards, the pension will be backdated to the date benefits were terminated under Section 30.

#41.11 Commencement Following Medical Review Panel Certificate

Where a pension is being revised following an examination and certificate by a Medical Review Panel, it is not proper to automatically make the adjustment only from the date of the certificate. While this may be correct in some cases, it is not defensible as a general policy.

Where a certificate of a Medical Review Panel is received indicating results that differ from previous decisions of the Board or findings of the former Workers' Compensation Review Board, it must be considered what further decisions are required as a proper response to the certificate of the Panel.

Suppose, for example, there has been a dispute from the outset about whether a worker is suffering from disability "A" (which is compensable), or disability "B" (which is not compensable). The Board decided that it was "B", and that decision was maintained throughout the appeal system. Suppose the Medical Review Panel then decided that the worker is suffering from "A". It may be agreed by all concerned that the worker has not changed from "B" to "A", and that if suffering from "A" now, the worker must have been suffering from "A" at the outset. In that circumstance, there is obviously entitlement to compensation as from the date when first suffering from the disability.

There may be another case where it is agreed by all concerned that the degree of disability has not changed, and yet the Medical Review Panel has concluded that the worker is suffering from a disability more extensive than that which the Disability Awards Medical Advisor or External Service Provider found. In that case too, the pension adjustment must be retroactive.

In a third case, it may appear that a different condition diagnosed by the Medical Review Panel has resulted from a recent change and, in such a case, it would be proper to commence the disability award from the date of the certificate. In a fourth case, it might appear that there was some progressive deterioration and,

in that case, a sliding scale may be appropriate so that the revised disability award is partially retroactive, but not to the full amount.

In other words, there can be no standard rule that a revised disability award should or should not be retroactive. The previous decisions on the claim must be reconsidered in the light of the certificate of the Panel, and new conclusions must be reached to whatever extent is necessary to give full effect to the certificate of the Panel.

EFFECTIVE DATE: March 3, 2003 (as to reference to the former Review Board)
APPLICATION: Not applicable.

#41.12 Retroactive Awards

Where a pension is awarded retroactively, the payments due prior to the date of the award will be paid in the form of a lump sum.

In calculating that sum, entitlement in respect of a portion of a month is determined by reference to the actual calendar days in a particular month. For example, if a worker is entitled to an award of $1,000 per month, for the period March 17 to 31 (15 calendar days), the calculation is as follows:

$$\frac{\$1{,}000}{31 \text{ days}} \times 15 \text{ days} = \$483.87$$

A reduction in the lump sum is made in respect of periods of time during the period following the commencement of the pension when the claimant received wage-loss or rehabilitation benefits. However, no such reduction is made when the pension is awarded in the form of a lump sum and the monthly equivalent is less than $20.00 per month at the time of the commutation.

The payment of interest on the lump sum is dealt with in #50.00.

#41.20 Termination of Pension

Pensions are normally payable throughout the claimant's lifetime, but for various reasons may be terminated prior to that time. For example, the claimant's disability may disappear, (12) the rule set out in #40.20 may result in a loss of earnings pension being wholly or partially terminated at age 65, or the Board may exercise certain powers discussed in #48.00 and #49.00.

In situations where a claimant in receipt of a pension dies from causes unrelated to the disability, the pension will be paid for the full month in which the death occurred. The past Board policy which came into effect on November 12, 1982 and required an apportionment of the pension in situations where there was no surviving dependants is rescinded. The effect of this policy will be that no overpayments will be considered to have arisen for the period from the date of the claimant's death up to the end of the month covered by the last pension payment.

If the worker dies prior to the implementation of the pension, the award is calculated and paid to the date of death. The situation where such a worker would have received a lump sum award is dealt with in #45.00.

#41.30 Pension Adjustments

If a pension to a worker or a dependant is paid or increased on the basis of a Review Division decision, and the finding is later reversed by the Workers' Compensation Appeal Tribunal, the pension payments are terminated or adjusted as of the date of the Workers' Compensation Appeal Tribunal decision. In such cases, the capitalization is adjusted by the reversal of an amount equivalent to the unused portion of the capitalization or, in the case of a modification, the adjustment applies to the amount of the capitalization affected by the modification. The policy regarding relief of costs to employers in such circumstances is detailed in policy item #113.10.

EFFECTIVE DATE: March 3, 2003 (as to references to Review Division and Workers' Compensation Appeal Tribunal)
APPLICATION: Not applicable.

#42.10 P.P.D. with Review

Sections 22 and 23 of the *Act* are designed to provide income support for a worker who has suffered a permanent disability. These sections are intended to be used only where the recovery or change process has, to all intents and purposes, become medically constant and stable. Realistically, such a circumstance is not totally practical since ongoing change is a feature of human physiology; but, within reason, it is designed to come into play where healing is complete or where the deterioration in the condition of the claimant has ceased and no improvement can be reasonably foreseen. P.P.D.'s with review, i.e. permanent partial disability awards with a provision for review in the future have been used in the past where the change process was still underway and where, therefore, the medical condition of the claimant was still "temporary". That practice was not in accord with the *Act* and was discontinued.

A permanent partial disability award decision may, however, be reopened where a ground for reopening is met (see Chapter 14).

EFFECTIVE DATE: March 3, 2003 (as to reference to reopening and deletion of reference to pension review)
APPLICATION: Not applicable.

#42.20 Worsening or Improvement of Disability

If the disability on which an award is based worsens, the extent of the disability is reassessed and a new award is made based on the reassessment. Conversely, if a worker should unexpectedly recover from a disability classified as permanent, the pension would be subject to termination or downward adjustment.

#42.30 Review of Old Pensions under Section 24

Section 24(2) provides that "With respect to a claim for compensation to which this section applies, the board must, on application by the worker, reconsider the compensation benefits; and, if it decides that, in its opinion, the worker is not receiving adequate compensation having regard to the projected loss of income resulting from the disability, periodic payments must be established or raised accordingly."

#42.31 Claims to Which Section 24 Applies

Section 24(1) provides that "This section applies to the claims for compensation that the board may by regulation determine, provided that

(a) the worker is still suffering from a compensable disability sustained more than 10 years before the application under subsection (2); and
(b) a permanent disability award was made by the board based on a percentage of total disability of 12% or greater, or the case is of a kind in which the board uses a projected loss of earnings method in calculating compensation."

Regulations have been issued by the Board which are set out below:

"1. The regulations come into effect on the 1st day of December, 1982.

2. The regulations with respect to the review of old disability pensions, promulgated by the Board on the 21st day of July, 1975, the 13th day of November, 1975, and the 19th day of August, 1976 (B.C. Regulations 524/75, 746/75 and 492/76) are hereby repealed.

3. Unless the Board otherwise determines, Section 24 of the *Workers Compensation Act* applies to claims in which all of the following conditions are present:

(1) The worker is still suffering from a compensable disability sustained more than ten years previous to the application under Section 24(2).

(2) A permanent disability award was made by the Board based on a percentage of total disability of 12% or greater, a disability award was made for an injury involving the spinal column, or a disability award was made for an injury to a part of the body other than the spinal column on or after October 1, 1977. Where the worker is still suffering from two or more compensable disabilities, this condition is satisfied if permanent disability awards were made by the Board which in aggregate were based on a percentage of total disability of 12% or greater, provided that a minimum of 5% of total disability was attributed to an injury or injuries sustained more than ten years previous to the application under Section 24(2)."

Clause 3(1) of these regulations does not mean that it is a requirement that each claim considered under Section 24 must be more than 10 years old. Where a worker has suffered several injuries with permanent disability resulting in several claims, the whole of the compensable disabilities resulting from these claims may be considered, provided that at least one of the compensable disabilities was sustained more than 10 years previous to the application under S. 24(2), and that a minimum of 5% of total disability was attributed to an injury or injuries sustained more than 10 years previous to the application.

The requirement in Clause 3(2) that the percentage of disability exceed 12% is a separate and independent requirement from Clause 3(1). Thus, it is not necessary that the disability award should have been made more than 10 years previous to the application, or that it should have been calculated at 12% or greater at any particular time.

The requirement in Clause 3(2) that a non-spinal disability of less than 12% be one that was assessed on or after October 1, 1977, in conjunction with Clause 3(2), means that no application for such a disability can be made under Section 24 until October 1, 1987.

Notwithstanding that a worker suffering a permanent disability has received an award that has been wholly or partly commuted, or an award for a fixed term, the worker may apply under this section, but he shall be deemed to be still receiving the periodic payments that have been commuted, or the life equivalent of the periodic payments made for a fixed term. (13)

#42.32 Calculation of Benefits under Section 24

Where a worker is under the age of 65 years, compensation is considered adequate for the purposes of this section if it equals 75% of the projected loss of earnings resulting from the disability. (14)

Section 24(4) provides that "Where a worker is 65 years of age or over, compensation is considered adequate for the purposes of this section if it equals 75% of the projected loss of retirement income resulting from the disability."

Where a worker is under the age of 65 years, periodical payments established or raised under this section are subject to readjustment by reference to Subsection (4) upon the worker attaining the age of 65 years. (15)

The calculation of benefits is made in the manner the Board determines. (16)

Where a worker is under the age of 65 years, the Board must determine the projected loss of earnings resulting from the disability. This involves three steps:

1. A forward projection of the earning capability of the worker as it existed prior to the disability.

2. A projection of the present earning capability of the worker.

3. A determination of the extent to which any difference between (1) and (2) is a result of the disability.

These calculations are made primarily by reference to evidence in the particular case, with two exceptions. A table of monthly average wage rates in B.C. (see Supplement No. 1, Appendix 5) is used to establish two of the variables; and an age factor is applied to those cases where the disability was suffered when the worker was under the age of 23. With regard to the former, a projection of the pre-disability earning capacity is made by comparing the claimant's actual pre-injury earnings, limited by the maximum in effect at the time of injury, with the monthly average wage rate in the table for that year and applying the same ratio to the average wage in the table for the year when the calculation is being made. In making this projection, no account is taken of promotions which the claimant might have obtained if he had not been injured.

Where a worker is 65 years of age or over, the Board must determine the projected loss of retirement income resulting from the disability. This involves a determination of:

1. The retirement income that the worker would have been likely to be receiving if he or she had not sustained the disability.

2. The retirement income the worker is receiving.

3. A determination of the extent to which any difference between (1) and (2) results from the disability.

Here again, the determinations are made to some extent by reference to evidence in the particular case; but two standard formulae are used with regard to two important items.

The first relates to retirement income from savings. Many workers save part of the earnings accrued during their working lives, and these savings, or income from the savings, become part of retirement income. The Board must consider,

therefore, the loss of this element of retirement income resulting from the disability. To determine loss of retirement income from savings, a standard formula is used, based on such evidence as the Board has been able to obtain from aggregated data relating to the savings habits of Canadian families.

The second item being considered by a standard formula is the loss of retirement income from earnings by people at and above the age of 65 years. The formula selected is to use a flat rate cash amount per month for each percentage of disability.

Where a worker's pension has been adjusted under Section 24 when under the age of 65 years and the worker has now reached that age, the readjustment is done in the following manner:

1. When an adjustment is made to a pension for a worker who is under the age of 65, that adjustment will be diarized for review three months prior to the worker attaining the age of 65.

2. When the matter comes up for review, the file will be considered in accordance with the procedures developed for calculating awards for workers aged 65 or over. For the purpose of this calculation, the original functional award in effect prior to any previous adjustment under Section 24, plus applicable Consumer Price Index increases, will be regarded as the pension in effect at age 65.

3. The term adjustment payable to age 65 will automatically terminate when the worker reaches age 65. The adjustment calculated as per item (2) above will then come into effect. This new pension will be the higher of the original pension award plus Consumer Price Index increases or the adjusted pension determined in reference to the calculation for workers aged 65 or over.

The detailed calculation formulae are set out in Appendix 5 to this manual.

#42.33 Maximum and Minimum Periodic Payments under Section 24

Section 31 applies to the calculation of compensation under Section 24, but the calculation is not limited by reference to average earnings at the time of injury. (17)

The periodic payments awarded to a worker following a review under this section shall not exceed the maximum that the Board would award to a worker in an occupational category similar to the occupation of the applicant worker before the injury if she or he had, at the effective date of the review under this section, suffered a compensable disability similar to the compensable disability being suffered by the applicant worker. (18)

No decision under this section shall result in periodical payments to any worker being lower than they would if no application had ever been made under this section. (19)

#42.34 Date when New Periodic Payments Commence under Section 24

Where a worker whose disability occurred before January 1, 1965 applies under this section within one year of the earliest date on which becoming eligible to do so, an increase or establishment of benefits under Section 24 is effective from September 1, 1975 and, in all other cases, the effective date for the commencement of an increase or establishment of benefits under the section is the date on which the application is received at the Board. (20)

The following table sets out when claimants whose disabilities occurred prior to January 1, 1965 became eligible to apply under Section 24.

Injury Occurred On or Before	**Date of Commencement of Eligibility**
December 31, 1925	August 1, 1975
December 31, 1928	September 1, 1975
December 31, 1932	October 1, 1975
December 31, 1936	December 1, 1975
December 31, 1940	January 1, 1976
December 31, 1944	February 1, 1976
December 31, 1948	April 1, 1976
December 31, 1952	May 1, 1976
December 31, 1956	June 1, 1976
December 31, 1960	July 1, 1976
December 31, 1964	August 1, 1976

#42.35 Reapplication under Section 24

A worker may reapply under this section for reconsideration of his compensation benefits after a further 10 years have elapsed since the last previous application under this section. (21)

#42.40 Reinstatement of Commuted Pensions under Section 26

Section 26(1) of the Act provides that "Where periodical payments for permanent disability were awarded by the board prior to January 1, 1966, and where

(a) the award was for a percentage of total disability of 12% or greater, and the whole of the periodical payments was commuted prior to that date;

(b) a portion of the periodical payments equivalent to 12% of total disability or greater was commuted prior to that date; or

(c) the award was for a percentage of total disability of 12% or greater and was of periodical payments for a fixed term,

and where the worker to whom the award had been made is still suffering from the disability, the board may, on the application of the worker, establish new periodic payments, which are to commence for the month in which the application is received at the board."

#42.41 Computation of Twelve Per Cent Disability

In determining the percentage of total disability represented by a commutation of periodical payments, the monthly dollar amount of the commutation should be compared with the monthly dollar amount of the periodical payments before the commutation, and multiplied by the percentage of total disability represented by the periodical payments before the commutation.

If the worker has had more than one commutation in respect of the same or different disabilities, the total value of the commutations and the disabilities is taken into account. In this case, all the commutations required to make the 12% must have occurred prior to January 1, 1966.

Consider the following example of a worker injured in 1936 who had two partial commutations, one in 1952 and one in 1955, who applied for reinstatement in September, 1974.

A.	True percentage of total disability awarded (as varied by age and wage factors)	61.20
B.	Monthly wage rate prior to injury	100.00
C.	Life value of pension per month	38.25
D.	Monthly amount of 1952 commutation	6.75
E.	1952 commutation as percentage of whole disability $\frac{D}{C} \times A = \frac{6.75}{38.25} \times 61.20$	10.80
F.	Remaining percentage of total disability (A-E)	50.40
G.	Balance of monthly pension (C-D)	31.50
H.	Recalculation of monthly pension following #39.61 $31.50 \times \frac{66\text{-}2/3}{62\text{-}1/2} \times \frac{2{,}000.00}{12 \times 100.00}$	56.00

I.	Monthly amount of 1955 commutation	2.00
J.	1955 commutation as percentage of whole disability (I x F) 2.00 x 50.40 H 56.00	1.80
K.	Total percentage of disability commuted (E + J)	12.60

In past years, the Board varied the assessed percentage of disability according to the earnings and age of the worker. In calculating the percentage of disability commuted for the purposes of Section 26, the disability as varied by these factors is used.

#42.42 Purpose of Section 26 Already Achieved

Section 26(5) provides that "This section does not apply where the purpose of the section has been achieved as a result of an application under Section 24 or in some other way."

Therefore, Section 26 has no application to a situation where, in the events that have occurred, a worker has not lost the future benefit of any cost of living increases by reason of the commutation. As under Section 26, however, such a worker receives future cost of living increases based on what the periodical payments would have been had they not been commuted.

To take an example, suppose a worker was receiving a pension for permanent total disability, and in 1964 arranged with the Board a partial commutation of that pension equivalent to $10.00 a month. If the remaining pension was increased pursuant to subsequent increases in the statutory minimum, it would, in November 1974, be $341.01 less $10.00 per month, i.e. $331.01. The increases in the minimum have exceeded the cost of living increases, and in the result, the worker has not lost any cost of living increases by reason of the commutation. As cost of living adjustments are now made, the worker will continue to receive the cost of living percentage applied to $341.01 so that the pension will continue to be the same as it would have been without the commutation, less the commuted $10.00 per month.

#42.43 Term Pensions

Where the award was for a fixed term that has not expired or been commuted, Section 26 applies upon the expiry of the term. (22) The worker must also wait the expiry of the term if he or she has to combine an expired or commuted pension with the term pension to satisfy the 12% requirement.

Occasionally, a term pension may be converted into a life pension if the worker is found to have an increased entitlement because of a deterioration in the pensionable condition. Section 26 is applicable as soon as the conversion takes place.

#42.44 Rate of New Periodic Payments

Section 26(3) provides that "In order to calculate the rate of new periodic payments to be established under this section, the board must determine

(a) the monthly payments that would have been payable on January 1, 1966 if the award had been of periodic payments for life and there had been no commutation, or, where the commutation was partial, the additional rate of monthly payments that would have been payable on that date if there had been no commutation; and

(b) the additional amount of monthly payments that would have been payable for the month during which the application is received by way of increases on the amounts calculated under paragraph (a) if those amounts had continued to be due; namely, the total of all increases that would have been made from January 1, 1966 to and including the last day of the month preceding the date the application is received."

The rate of the new periodical payments is the amount calculated under clause (b). (23)

Consider the following examples:

1. Worker injured in 1938. Term award which expired in 1952. Application under Section 26 in February, 1976.

   A. True percentage of total disability awarded (as varied by age and wage factors) — 18.58%

   B. Monthly wage rate prior to injury — $80.00

   C. Life value of pension per month (24)
   $\frac{18.58}{100}$ (A) x $\frac{62\text{-}1/2}{100}$ x 80.00 (B) — $9.29

   D. Monthly pension that would have been payable if there had been no term award under provision in #39.61 (Section 33(4))
   9.29 (C) x $\frac{66\text{-}2/3}{62\text{-}1/2}$ x $\frac{2{,}000.00}{12 \times 80.00\ (B)}$ — $20.64

   E. Provision in #39.62 inapplicable as would result in pension less than under #39.61

   F. C.P.I. from January 1, 1966 to January 1, 1976, on $20.64 (D)
   76.3452% of $20.64 — $15.75

G. New monthly periodical payments under Section 26 commencing February 1, 1966 $15.75

2. Claimant injured in December, 1944. Commuted part of permanent partial disability pension in 1950. Application under Section 26 in November, 1974.

A. True percentage of total disability awarded (as varied by age and wage factors) 40.97%

B. Monthly wage rate prior to injury $150.00

C. Life value of pension per month

$$\frac{40.97}{100} \text{ (A) x } \frac{66\text{-}2/3}{100} \text{ x 150.00 (B)}$$

$40.97

D. Monthly amount commuted $14.95

E. Percentage of total disability commuted

$$\frac{14.95 \text{ (D) x } 40.97 \text{ (A)}}{40.97 \text{ (C)}}$$

14.95%

F. Provision in #39.61 inapplicable as injury occurred after March 18, 1943

G. Additional monthly pension that would have been payable had there been no commutation under provision in #39.62

$$\frac{14.95 \text{ (E) x } 130.00}{100}$$

$19.44

H. C.P.I. on additional monthly pension (G) from January 1, 1966 to July 1, 1974
49.85% of $19.44 $9.69

I. Additional monthly periodical payments under Section 26 commencing November 1, 1974 (to be added to existing pension) $9.69

#42.45 Consumer Price Index Adjustment After Reinstatement

Consumer Price Index adjustments after the establishment of the new periodical payments are based on the sum of the amounts calculated under clauses (a) and (b) in #42.44. (25) A formula for calculating these adjustments, which applies both in cases of total and partial commutation is set out below.

Where the commutation was partial, so that part of the original pension is still subsisting, the residue of the original pension may be blended with the reinstated pension under Section 26. Where the commutation was total, the formula applies to the reinstated pension, and where the commutation was partial, it applies to the blend of the residue of the original pension with the reinstated pension.

The formula is:

1. The amount of pension benefits being paid for the month preceding the C.P.I. increase $

PLUS

2. The monthly amount of pension that had been commuted $

Subtotal $

3. The application of the C.P.I. adjustment ratio to that subtotal $

Second Subtotal $

LESS

4. The monthly amount of pension that had been commuted $

Total $

The resulting total is the monthly pension that will be applicable after the C.P.I. increase.

#42.46 Commutation of New Periodic Payments

Generally, no commutation will be allowed in respect of the new periodical payments awarded under Section 26. However, the Board does have discretion to permit this in unusual cases.

#43.00 DISFIGUREMENT

Section 23(5) of the Act provides:

> "Where the worker has suffered a serious and permanent disfigurement which the board considers is capable of impairing the worker's earning capacity, a lump sum in compensation may be paid, although the amount the worker was earning before the injury has not been diminished."

#43.10 Requirements for Award

Section 23(5) establishes the following requirements:

1. The disfigurement must be "permanent". A temporary disfigurement is not sufficient.

2. The disfigurement must be "serious". No award will be made if the disfigurement is minimal.

3. The disfigurement must be one that the Board considers capable of impairing the worker's earning capacity. This is normally assumed in cases of the head, neck and hands. In other cases, a decision must be made which has regard to the age and occupation of the worker, the visibility and extent of the disfigurement and any other relevant circumstances. Since Section 23(5) states that the amount the worker is currently earning does not have to be diminished, this requirement is concerned with the worker's long-term earning capacity.

Where there is disfigurement as well as a permanent disability, the worker may receive awards for both. Subject to the Board applying Section 35(2) of the Act (see #45.00), the award for the permanent disability is a pension, and the award for disfigurement a lump sum. These awards must be assessed separately.

Disfigurement is concerned with the appearance of the body, not loss of bodily function. Therefore, a loss of skin function, for example, soreness or itchiness or unusual sensitivity to light, heat or humidity, will be considered for a permanent disability rather than a disfigurement award. The granting of an award will depend on the normal criteria for permanent disability awards.

The ultimate aim of disfigurement and permanent disability awards is to compensate for loss of earning capacity. The worker should not receive double compensation for the same loss. No disfigurement award is granted for something which is directly covered by a permanent disability award, for

example, the deformity caused by the normal appearance of an amputated limb. A disfigurement award may be considered where the appearance of an impairment for which a permanent partial disability award has been granted is disfiguring to an exceptional degree.

If the worker receives an award of 100% on a physical impairment basis under Section 23(1), or an award for total unemployability under Section 23(3), there is no additional loss of earning capacity which can form the basis for a disfigurement award.

Where psychological disability results from disfigurement, consideration will be given to a permanent disability award under Section 23(1) or 23(3) following the normal practices for such awards (see #22.33).

#43.20 Amount of Award

In calculating the amount of an award, the guidelines set out below apply:

1. Points are assigned to each of five factors assessed individually according to the table set out below. The assessment will normally be based on photographs of the worker but there may also be a visual examination of the worker in exceptional cases. The Board officer will give reasons for the points assigned to each factor.

POINTS / FACTORS	0–24 POINTS	25–49 POINTS	50–74 POINTS	75–99 POINTS
Surface area of part of body (see guideline 3)	Less than 25%.	25%–49%.	50%–74%.	75% or more.
Texture and thickening. **keloid scarring** hardening.	Mild alteration of texture. Slight wrinkling, furrows or marks.	Moderate thickening. Moderate hardening. Mild dryness or scaling. Prone to pimples.	Major thickening. Major hardening. Moderate dryness or scaling. Frequent pimples. Prone to ulceration.	Severe Severe Major dryness or scaling. Frequent ulceration. Significant irregularity of scar.
Colour .	Mild alteration of colour.	Moderate alteration of colour.	Major alteration of colour.	Severe alteration of colour.
Visibility	Less than 25% visible with work clothing.	25 to 49% visible with work clothing.	50 to 74% visible with work clothing.	75% visible or greater with work clothing.
Loss of bodily form.	Mild depression or elevation.	Moderate depression or elevation	Major depression or elevation. Moderate to major atrophy. Moderate to major irregularity of body.	Severer depression or elevation. Severe muscle or tissue loss.

2. An average is taken of the points assigned by dividing the total points by five and the disfigurement is placed in one of four classes as follows:

Class 1	0 to 24 points
Class 2	25 to 49 points
Class 3	50 to 74 points
Class 4	75 to 99 points

3. The area of the body affected is determined. Five areas are recognized. A minimum and maximum award exists for each of the four classes for each area of the body as shown in the following table:

January 1, 2002 – December 31, 2002

	Minimum	**Maximum**
Head and Neck		
1.	$ 0.	$ 4,656.80
2.	4,656.80	9,313.59
3.	9,313.59	28,289.97
4.	28,289.97	47,149.97
Each Hand		
1.	$ 0.	$ 1,513.46
2.	1,513.46	3,143.33
3.	3,143.33	9,313.59
4.	9,313.59	15,716.64
Each Arm		
1.	$ 0.	$ 1,164.18
2.	1,164.18	2,328.39
3.	2,328.39	7,101.59
4.	7,101.59	11,758.40
Each Leg (including the foot)		
1.	$ 0.	$ 814.93
2.	814.93	1,513.46
3.	1,513.46	4,656.80
4.	4,656.80	7,800.12

Torso

1.	$ 0.	$ 814.93
2.	814.93	1,513.46
3.	1,513.46	4,656.80
4.	4,656.80	7,800.12

The above figures are 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).

4. The amount of the award is (subject to the minimum) the percentage of the maximum dollar amount for the class that the average points for the disfigurement bears to the maximum points assigned to the class. For example, if the average points for a hand disfigurement is 6, it is assigned to Class 1 of the hands area of the body and the amount of the award is $325 ((6/24) x $1,300). If a burn to the chest is assigned an average of 34 points, it is in Class 2 of the torso area of the body and the amount of the award is $897 ((34/49) x $1,300).

Detailed examples of the application of the above guidelines are set out below:

Example 1

The worker has a loss of the fingernail and nailbed, slight shortening of the right mid finger, a small curved raised nail growing through the graft at the injury site. Assuming that the disfigurement were found capable of impairing earning capacity, the award would be calculated as follows:

Factors	Description	Points
Surface area	Less than 25%	2
Texture / keloid	Minimal alteration; no keloid	2
Colour	No contrast	0
Visibility	Less than 25%	20
Structure	Mild evidence of depression	5

A. Total points are 29.

B. Average points are 6 (29/5). Disfigurement is in Class 1.

C. Determine % which average points in line B bears to maximum points for Class 1 = 25% (6/24).

D. Apply % from line C to maximum dollar amount for Class 1 for the hands area = $325 (25% of $1,300).

Amount awarded is $325.

Example 2

The worker has healed burns that extend up the right side and front of the abdomen and chest. There is evidence of occasional ulceration and moderate irregularity of the scars. Scar colour is significantly different when compared to unaffected skin. Assuming that the disfigurement were found capable of impairing earning capacity, the award would be calculated as follows:

Factors	Description	Points
Surface area	Less than 25%	20
Texture / keloid	Some puckering and contraction; moderate keloid, scars raised to 3 mm	70
Colour	Significant contrast	80
Visibility	Nil	0
Structure	No evidence of depression or elevation other than keloid	0

A. Total points are 170.

B. Average points are 34 (170/5). Disfigurement is in Class 2.

C. Determine % which average points in line B bears to maximum points for Class 2 = 69% (34/49).

D. Apply % from line C to maximum dollar amount for Class 2 for the torso area = $897 (69% of $1,300).

Amount awarded is $897.

#44.00 PROPORTIONATE ENTITLEMENT

Section 5(5) provides that "Where the personal injury or disease is superimposed on an already existing disability, compensation must be allowed only for the proportion of the disability following the personal injury or disease that may reasonably be attributed to the personal injury or disease. The measure of the disability attributable to the personal injury or disease must, unless it is otherwise shown, be the amount of the difference between the worker's disability before and disability after the occurrence of the personal injury or disease."

This subsection deals with cases where the compensability of the immediate injury and disability has been accepted by the Board. It does not concern itself with the initial adjudication as to the causation of the particular disability.

#44.10 Meaning of Already Existing Disability

The mere fact that the worker suffered from some weakness, condition, disease, or vulnerability which partially caused the personal injury or disease is not sufficient to bring Proportionate Entitlement into operation. The pre-existing condition must have amounted to a disability prior to the occurrence of the injury or disease.

Three situations are distinguished:

1. In cases where it has been decided that the precipitating event or activity, and its immediate consequences, were so severe that the full disability presently suffered by the claimant would have resulted in any event, regardless of any pre-existing disability, Section 5(5) should not be applied.

2. In cases where the precipitating event or activity, and its immediate consequences, were of a moderate or minor significance, and where there is only x-ray evidence and nothing else showing a moderate or advanced pre-existing condition or disease, Proportionate Entitlement should not be applied. These cases should not be classified as a disability where there are no indications of a previously reduced capacity to work and/or where there are no indications that prior ongoing medical treatment had been requested and rendered for that

apparent disability. In determining whether there has been ongoing treatment, regard will be had to the frequency of past treatments and how long before the injury they occurred.

3. Where the precipitating event or activity, and its immediate consequences, were of moderate or minor significance, but x-ray or other medical evidence shows a moderate to advanced pre-existing condition or disease, and there is also evidence of a previously reduced capacity to work and/or evidence of a request for and rendering of medical attention for that disability, Section 5(5) should be applied.

These rules apply to all permanent partial disability awards assessed on or after March 15, 1978.

Section 5(5) only applies where an injury is "superimposed" on an already existing disability. The injury and the existing disability must be in the same part of the body.

The fact that the claimant has an award from another agency for a pre-existing disability does not affect this Board's practise. The Board makes its own assessment of the pre-existing disability and is not bound by the percentage awarded by the other agency.

#44.20 Temporary Disability and Health Care Benefits

It is not the policy of the Board to apply the provisions of Section 5(5) to health care benefits or temporary disability benefits. Ordinary wage loss will be paid on the simple presumption that the claimant was fit and able to carry on regular duties prior to the injury and is, at the time of receiving wage-loss benefits, totally or partially unable. The only conclusion to be derived from these facts is that the injury itself is the sole cause of that immediate total or partial disability. Proportionate Entitlement is thus a concept applicable only to permanent disability awards.

#44.30 Permanent Disability

Where a worker already has a pre-existing disability, and suffers a work injury resulting in an aggravation of the disability, wage-loss compensation is paid for the period of any temporary total disability. If the aggravation was temporary only and the worker recovers from the aggravation so that she or he is restored to the position of the pre-existing disability, there is then no residual disability resulting from the work injury, and therefore no further compensation. However,

where a pre-existing disability is permanently aggravated by the work injury, and the worker's condition has stabilized, the Board must then consider how much is the compensable aggravation.

Assuming that a pre-existing impairment has been established, Section 5(5) requires that compensation shall be allowed only for such proportion of the claimant's "disability" as may reasonably be attributable to the personal injury or disease. "Disability" again means loss of body function or physical impairment.

The measure of the disability attributable to the personal injury or disease shall, unless it is otherwise shown, be the amount of the difference between the worker's disability before and disability after the occurrence of the personal injury or disease. (27)

The Board's practice in relation to Section 5(5) has no relevance to conditions which arise after the injury. It is only concerned with pre-existing problems. The Board's practice is that it will apportion its responsibility in respect of a disability attributable to causes other than the work injury arising after the injury.

Consider the example of a worker whose average earnings are $1,000 per month and who, following a work injury, has a 10% disability. If the whole of that disability is attributable to the injury, the monthly pension awarded on a physical impairment basis is 75% of 10% of $1,000, i.e. $75.00 a month. If, however, 3% out of the total impairment existed prior to the injury, Section 5(5) requires that compensation only be awarded in respect of the 7% caused by the injury. The worker would therefore receive 75% of 7% of $1,000 per month, i.e. $52.50.

#44.31 Application of Proportionate Entitlement to the Dual System

In every case where there was a pre-existing disability, the Board has to decide whether the loss of earnings experienced by the worker after the injury is wholly the result of the compensable disability or partly the result of the pre-existing disability. If it decides that the whole loss is the result of the compensable disability, no reduction in the pension is made under Section 5(5). If it decides that a portion of the loss is attributable to the pre-existing disability, a pension is only awarded for the portion attributable to the compensable disability.

The Board feels that this is fair to claimants in that it allows for the fact that their pre-injury earnings may already have been reduced by the pre-existing disability. On the other hand, it ensures that the Board does not become responsible for loss of earnings which are really attributable to the delayed or progressive effect of non-compensable pre-existing disabilities. The Board recognizes that it is often difficult in practice to properly allocate the causes of a loss of earnings where there is pre-existing disability, but do not feel that it is any more difficult than other decisions that have to be made under the Act, or that this difficulty justifies a different interpretation of Section 5(5).

Consider, for example, a worker with a pre-existing disability determined to be 40% of total disability, who, following a back injury, has a disability of 60% of total disability. Assume the average earnings of the worker prior to the injury were $1,000.00 per month and he or she has suffered a total loss of earnings following the injury which is partly attributable to a pre-existing disability.

A. Physical Impairment Method

Amount that would be payable for a total disability – (75% x $1,000.00)	$750.00
Partial disability pension after application of Proportionate Entitlement (60% – 40% = 20% x $750.00)	$150.00

B. Projected Loss of Earnings Method

Projected loss of earnings	$1,000.00
75% of projected loss of earnings	$750.00
Partial disability pension after application of Proportionate Entitlement (20% / 60% x 100 = 33-1/3% x $750.00)	$250.00

#44.40 Disabilities Arising Prior to April 6, 1968

Prior to 1968, the relevant provision of the Act, Section 7(5), read as follows:

> "Where the personal injury consists of injury or disease in part due to the employment and in part due to causes other than the employment or where the personal injury aggravates, accelerates, or activates a disease or condition existing prior to the injury, compensation shall be allowed for such proportion of the disability as may reasonably be attributed to the personal injury sustained."

This subsection, of course, continues to apply to all disabilities arising prior to April 6, 1968, when the new subsection was proclaimed.

#45.00 LUMP SUMS AND COMMUTATIONS

Section 35(2) of the *Act* provides:

The board may in its discretion

(a) commute all or part of the periodic payments due or payable to the worker to one or more lump sum payments, to be applied as directed by the board; and

(b) divide into periodic payments compensation payable in a lump sum.

In case of death or permanent total disability or in case of permanent partial disability where the impairment of earning capacity exceeds 10% of the worker's earning capacity at the time of the injury, no commutation of periodic payments can be made under subsection (2) except upon the application of and at an amount agreed to by the dependant or worker entitled to such payments. (28)

#45.10 Pension Categories/Lump Sum Awards

Category A:

Where

1. a compensable disability has been assessed at not more than 10% of total disability, and

2. the pension is not more than $200.00 per month,

a lump sum will be awarded in lieu of a monthly pension.

Category B:

In any case not within Category A, where the pension is more than $200.00 per month, the award will consist of a monthly pension and commutation will only be considered under the circumstances outlined below.

Where a worker or dependant has more than one disability pension or dependant benefit on one or more claims, the above figures apply to the combined total. Where the worker or dependant has had previous commutations or lump sum awards, these previous awards are not applied to the combined total.

Where a commutation request is made after the award of a pension or dependant benefit, the monetary level at the date of the request is used rather than the level at the date of the award.

A review of the monetary level in Categories A and B will be undertaken annually. Any changes to the amount will normally take place on the first day of the month following the month of the review.

The amount set out above is effective October 1, 2002. If required, earlier figures may be obtained by contacting the Board.

#45.20 Criteria for Allowing or Disallowing a Commutation

The same criteria apply, whether or not the Board has recovered all or part of the capital reserve in a third party action.

Workers granted awards that fall within Category A will automatically be given a lump sum award.

The general rule is that no commutation will be granted for cases in Category B.

There are, however, certain situations where a commutation may be desirable. The purpose of the guidelines set out below is to define those situations where it is in the worker's long term interests to receive a commutation and to state the terms and conditions on which such commutations are granted.

In considering a commutation, the following will apply:

1. A commutation must be for a specific purpose.

2. A commutation will, in general, only be allowed for purposes that are calculated to enhance the income position of the worker.

3. The applicant must have a stable source of income other than the disability pension.

4. A commutation will not be allowed where the applicant is a person whom the Board considers incapable of managing his or her own affairs or who has a demonstrated incapacity for money management.

5. Where there is an application by a widow or widower to commute a pension which is paid in whole or part for the children regard may have to be had to the separate interests of the children.

6. If the other requirements are met, a commutation may be in the worker's long term interests notwithstanding the worker's medical condition may not have settled or involves a significant risk of deterioration. However, while a potential deterioration in the worker's condition will not automatically bar a request, it is a relevant factor to be considered. It might, for instance, lead to a conclusion that the worker's existing income from other sources would not be stable from a long-term point of view.

   Similarly, the fact that a disability may improve in the future will not automatically bar a request for a commutation, even though the commutation will prevent the Board from reducing the pension when the improvement occurs. The possibility of such an improvement may, however, be taken into account if it is significant. It may influence the amount of commutation granted.

7. A short expectation of life or a worker's wish to benefit the dependants following his or her death is not a ground on which the Board can permit a commutation.

EFFECTIVE DATE: March 1, 2007

APPLICATION: The amendments to this policy, that term commutations are no longer available, brought into effect by BOD Resolution No. 2007/01/23-02, apply to all applications for commutations made on or after March 1, 2007.

HISTORY: This policy was amended effective October 1, 2002. Changes were made to the threshold amounts for automatic commutations and the criteria for considering commutations were broadened. Please refer to BOD Resolution No. 2002/08/27-04 for details of the amendments. The policy as amended October 1, 2002 applies to all new claims received, all active claims that were awaiting an initial permanent disability award adjudication, and all active claims that were awaiting initial adjudication of periodic payments of compensation to a dependant of a deceased worker, on or after October 1, 2002. The policy as amended October 1, 2002 does not apply to workers in receipt of a permanent disability award or pension based on a projected loss of earnings that was initially adjudicated before October 1, 2002.

#45.21 Death of Worker Prior to Award under Category A in Policy Item #45.10

Under the terms of the *Act*, disability awards are payable to a worker. There is no provision for a disability award to be payable in respect of a deceased worker.

The *Act* distinguishes between two different categories of benefits:

1. Benefits payable to a disabled worker.

2. Benefits payable to dependants and others in respect of the death of a worker.

No compensation under the first heading can validly be awarded in respect of future disability after the death of a worker. Where future benefits have been issued after the death of a worker, the benefit will be cancelled and recalculated up to the date of the worker's death.

#45.30 Types of Commutations Permitted

There are two types of commutations that the Board may permit:

1. A partial commutation resulting in a reduced level of pension for life.

2. A full commutation of the whole pension for life.

To ensure that a commutation is used for the purpose for which it is sought, the Board may make a commutation cheque payable to a worker and to another.

EFFECTIVE DATE: March 1, 2007

APPLICATION: This policy applies to all applications for commutations made on or after March 1, 2007.

#45.40 Purpose of Commutations

Certain purposes for which commutations are commonly requested are discussed below. The list is not intended to cover every purpose for which a commutation may be requested but rather is designed to provide guidelines to ensure the consistent handling of certain common types of application.

#45.41 Paying Off Debts

The Board is concerned that lenders might be encouraged to grant excessive extensions of credit to pensioners if they became aware that commutations could easily be obtained to pay off debts. Section 15 of the *Act* seeks to protect workers from creditors by making pension payments non-assignable. The Board will not undermine this intention by freely allowing commutations for the purpose of debt reduction. Therefore, a commutation is more likely to be allowed for paying off debts that were incurred prior to the injury.

A person incurring heavy debt may have serious long-term problems which will not be resolved simply by a commutation to pay debts. These problems may lead to incurring further debt even if the existing debt is paid. The person will then be in an even more serious position than before because there will now be no pension. It may, in such cases, be more appropriate to refer the pensioner for financial counselling rather than to attempt to resolve the situation by a commutation of pension payments. Nevertheless, a commutation to pay off debts may be advisable and in the best interests of the worker if it will avoid high interest obligations. Commutation applications for this purpose will be carefully scrutinized for other alternatives before being allowed.

#45.42 Investments

A commutation will not be allowed for investment purposes.

#45.43 Starting a Business

From a purely financial standpoint, it may be difficult to distinguish between investing in one's own business and other forms of investment. It is, moreover, often difficult for officers of the Board to determine with any degree of certainty whether what the worker wishes to undertake is a sound business venture. Investing in one's own business, however, may be in the worker's best interests where there is a strong element of rehabilitation involved and the worker will be an active participant in operating the business. Any application for a commutation for the purpose of starting a business will be thoroughly investigated with these considerations in mind.

In each case where a business start-up is contemplated for which a commutation has been requested, or as a vocational rehabilitation measure, the Board officers undertaking the assessment of the matter will obtain, with the worker's written consent, an appraisal of the viability of the proposed business from the Business Development Bank of Canada or some similar organization before a final decision on the commutation request, or rehabilitation measure, is made.

#45.44 Education

Unless the proposed educational program will promote the worker's career, a commutation for this purpose would not normally enhance the worker's income position and consequently would not satisfy the above general guidelines. There may, however, be some therapeutic benefit in allowing pensioners to improve their education when the improvement cannot be provided through normal rehabilitation programs. The requirement for the applicant to have a stable source of income may be waived where the Board is satisfied that the training or educational program will increase the prospects of employment and therefore enhance the income position over the long term. Where the program will not

increase the employment prospects, but will have a significant therapeutic benefit, the Board may waive the requirement that the commutation be for a purpose that enhances the worker's income position. In such a case, it will not waive the requirement that the applicant have a stable source of income.

#45.45 Buying a Home

Commutations for purchasing a home will be allowed under the following conditions:

1. The home is purchased as a personal residence.

2. The worker will obtain clear title to the property subject only to any mortgage.

3. Any mortgage payments are well within the worker's ability to pay from other income.

4. The size, value and upkeep costs of the home are in line with other income.

The discharge or reduction of an existing mortgage will be dealt with under the criteria for paying off debts in policy item #45.41, rather than under the criteria for buying a home. In administering this feature, however, a request for a commutation to discharge or reduce an existing mortgage should primarily be considered in the same general vein as a commutation to purchase a home, with the added insurance that consideration should be given to the safeguards built into the debt payment provisions. The expectation of this approach is that, in general, given similar circumstances, there should be little difference in the result following a decision made under either category.

A commutation for the purpose of extending an existing home may be allowed if the above requirements are satisfied.

A commutation will not normally be allowed for the purpose of purchasing a second home to be used for vacations, or retirement, or to be rented out. The home must be for the purpose of providing the claimant with current accommodation.

#45.50 Decision-Making Procedures

The Board officer in Disability Awards is responsible for investigating an application for a commutation and making a decision on the application. The Board officer may obtain a report from the Board officer in Vocational Rehabilitation Services involved in the claim before making a decision.

Where a commutation application is under consideration, the value of the proposed commutation can be made available so that the claimant may properly evaluate the options open.

If the value of a commutation under Category B in policy item #45.10 exceeds the limit set in Category A, the Board officer must obtain approval of the Vice-President, Compensation Services Division before granting the request. Where an application is received that does not fall within the guidelines and it is thought that there should be some departure, the application must also be referred to the Vice-President for consideration.

An employer is not normally advised of the granting of a commutation. An exception is made where the employer is the Federal Government. It is advised of the amount and type of the commutation.

#45.60 Amount Paid on Commutations

When a pension reserve is established or a liability is calculated for a pension, the monthly pension amount is converted to a lump sum by applying an actuarial net discount rate. This actuarial net discount rate is set by the Board and represents the anticipated difference between long term future investment returns and long term future inflation.

Similarly, when a pension commutation is granted, the monthly pension amount is converted to a lump sum by applying a commutation net discount rate. For pensions that are automatically commuted by the Board without a request from the worker, the commutation net discount rate used will be equal to the actuarial net discount rate. For pensions that are commuted by the Board at the worker's or dependant's request, the commutation net discount rate used will be equal to the actuarial net discount rate increased by .5 percentage points.

#45.61 Calculation of Lump-sum Payment or Commutation

Where, as a result of the application of the policies outlined in policy items #45.10 to #45.60, the Board officer in Disability Awards decides on a lump sum or commutation, it is paid forthwith.

Whenever a lump-sum payment or commutation is calculated following the review or appeal process, the calculation will be based on the date on which it is processed.

EFFECTIVE DATE: April 8, 2003
APPLICATION: To all decisions made on or after April 8, 2003.

NOTES

(1) See #66.12
(2) See #51.13
(3) See #40.00
(4) S.23(2)
(5) Permanent Disability Evaluation Schedule Appendix 4
(6) See #25.10
(7) Decision No. 157
(8) S.23(4); See #34.20
(9) See #37.21
(10) S.33(4)
(11) See #66.20
(12) See #42.20
(13) S.24(7)
(14) S.24(3)
(15) S.24(5)
(16) S.24(6)
(17) S.24(8)
(18) S.24(9)
(19) S.24(12)
(20) S.24(11)
(21) S.24(10)
(22) S.26(2)
(23) S.26(4)
(24) The 62-1/2% shown in the equation is the percentage of average earnings used in 1938 for calculating compensation, the equivalent of the present 75%
(25) S.26(4)
(27) S.5(5)
(28) S.35(3)

CHAPTER 7

PROTECTION OF AND DEDUCTIONS FROM BENEFITS

#46.00 INTRODUCTION

The *Workers Compensation Act* contains provisions which prevent an employer from inhibiting a worker from claiming compensation and prevent persons from obtaining the funds which the Board owes to the claimant. There are however, exceptional cases where benefits may be diverted to someone other than the claimant or deductions made in respect of money the claimant owes to others.

The Act and the Board's policies also contain provisions which ensure that the monetary value of benefits is not unfairly reduced because of inflation or delays in its being paid by the Board.

#47.00 ACTIONS BY EMPLOYERS

The obligations of an employer to report the occurrence of industrial injuries and diseases to the Board and to refrain from inhibiting a claimant from reporting such occurrences to the Board are discussed in #94.00. Set out below are some additional provisions which prevent an employer from directly or indirectly attempting to prevent claimants from exercising their right to receive Workers' Compensation.

#47.10 Agreements to Waive or Forego Benefits

Section 13(1) provides that "A worker may not agree with his or her employer to waive or to forego any benefit to which the worker or the worker's dependants are or may become entitled . . ., and every agreement to that end is void."

This provision is applicable whether a contract provides in express terms that no benefits under the Act are payable to a worker of the employer, or whether it seeks to achieve the same objective by more subtle means, such as by describing the parties as independent contractors in circumstances in which the relationship is, in substance, one of employment. Where there is any suggestion that Section 13 has been violated, the claim should be referred immediately to a Director, Claims.

#47.20 Contributions from Workers to Employer

Section 14 provides as follows:

"(1) It is not lawful for an employer, either directly or indirectly, to deduct from the wages of the employer's worker any part of a sum which the employer is or may become liable to pay into the accident fund or otherwise under this Part, or to require or to permit his worker to contribute in any manner toward indemnifying the employer against a liability which the employer has incurred or may incur under this Part.

(2) Every person who contravenes subsection (1) commits an offence and is liable to repay to the worker any sum which has been so deducted from his or her wages or which he or she has been required or permitted to pay in contravention of subsection (1)."

The maximum fine for the offence referred to in Subsection (2) is set out in Part 1 of Appendix 6.

#48.00 ASSIGNMENTS, CHARGES OR ATTACHMENTS OF COMPENSATION

Section 15 of the Act provides that "A sum payable as compensation or by way of commutation of a periodic payment in respect of it is not capable of being assigned, charged or attached, nor must it pass by operation of law except to a personal representative, and a claim must not be set off against it, except for money advanced by way of financial or other social welfare assistance owing to the Province or to a municipality, or for money owing to the accident fund."

#48.10 Solicitors' Liens

The statutory lien provided for solicitors under Section 79 of the *Legal Profession Act* is not applicable to workers' compensation. If the solicitor would have any right to a lien at common law or in equity, that right is abrogated by the terms of Section 15 of the *Workers Compensation Act*. Compensation funds cannot, therefore, be paid to a solicitor acting for a claimant. Nor would it be right for the Board to induce the same result in a more devious way by making the cheque payable to the claimant and sending it in care of the solicitor.

#48.20 Money Owing by Worker to Other Agencies

Workers frequently receive benefits from other governmental or non-governmental agencies while awaiting the adjudication or a review or appeal of their compensation claim. If they eventually receive compensation benefits for the same period, the agency may have a claim against them for reimbursement of the funds advanced by it. A Provincial Government agency or a municipality

can claim reimbursement for money advanced to the worker as financial or other social welfare assistance.

The restrictions on the attachment and assignment of compensation created by section 15 of the *Act* do not generally apply to the Federal Government. As a result, in some instances, the Federal Government could also claim reimbursement for payments made under federal programs.

In the case of health and welfare plans or similar insurance plans, while the *Act* in section 15 does not permit direct refunds to such agencies, the Board may, on receipt of a worker's signed authorization, mail cheques payable to the worker in care of the agency.

In those cases where an inquiry is received from an insurance company or other health and welfare plan, the Board officer may provide the requested information as long as a signed consent from the worker is on file identifying both the Workers' Compensation Board and the insurance company. See also policy item #99.80.

EFFECTIVE DATE: July 13, 2005
APPLICATION: Benefits, including retroactive awards of benefits, payable under the *Workers Compensation Act* on or after July 13, 2005.

#48.21 Employment Insurance

The essence of the arrangement between the Canada Employment and Immigration Commission and the Board, as reflected in the respective statutes, is that where a person is eligible for workers' compensation, the Board is in the position of first payer. If a worker receives Employment Insurance benefits and subsequently receives workers' compensation benefits in respect of the same period, under the *Unemployment Insurance Act* the worker is under an obligation to reimburse the Canada Employment and Immigration Commission; but that is a matter between the worker and the Commission. There is no provision under the *Workers Compensation Act* for compensation benefits to be withheld because of the receipt of Employment Insurance benefits.

EFFECTIVE DATE: July 13, 2005
APPLICATION: Benefits, including retroactive awards of benefits, payable under the *Workers Compensation Act* on or after July 13, 2005.

#48.22 Welfare Payments

Deductions from compensation may be made in respect of welfare payments made to the worker by the Ministry of Social Services or by city or municipal Social Welfare Departments.

At one time, welfare assistance was provided by individual municipalities, but it is now provided exclusively by the Provincial Ministry of Social Services. The practice is that when a person who may be entitled to compensation is awarded welfare assistance, the Ministry may require the person to execute an assignment to the Ministry of any benefits received from the Board. The assignment is then passed on to the Board to notify it to deduct from the claimant's compensation benefits the amount owed to the Ministry.

The rules set out below are followed in respect of assignments of compensation made by claimants to the Ministry of Social Services.

1. No overpayment of compensation is declared and sought to be recovered in respect of payments of compensation made prior to the receipt of an assignment of benefits made by a claimant to the Ministry.

2. In respect of payments of compensation made after receipt of the assignment:

   (a) **Wage Loss**

   Refunds will only be made to the Ministry for wage-loss periods which are concurrent with periods where assistance has been paid and only up to the amount of the assistance paid for that period.

   (b) **Monthly Pension Benefits**

   The Ministry will be refunded up to the monthly value of the pension for concurrent periods. This will usually apply only to retroactive payments. Ongoing assistance, if being paid, will be adjusted by the Ministry beyond the implementation date of the award.

   (c) **Pension Benefits: Cash Awards or Commutations**

   Where a cash award or commutation is granted, the Ministry will be reimbursed the equivalent amount of the monthly pension value of the commutation or lump sum payment that would otherwise have been payable to the claimant. This will be for the same period of time covered by the assistance payment. This will only apply up to the amount of assistance paid by the Ministry for that period. This will generally only occur where the cash award or commutation is being paid on a retroactive basis.

(d) **Rehabilitation Allowances**

The Ministry has agreed not to request an Assignment of Benefits from rehabilitation allowances paid under Section 16 of the *Workers Compensation Act*.

3. Where no payments of compensation on the claim are due after receipt of the assignment or the payments cease before the full amount owed to the Ministry is paid off, the Ministry is advised that it will have to collect the amount outstanding through other means.

The claimant is advised when welfare payments are being deducted from workers' compensation benefits.

#48.23 Requirements to Pay

The Board may receive written notice requiring that benefits owing to a worker be redirected, in whole or in part, to the Federal Receiver General on account of the worker's debt under the *Income Tax Act* or the *Excise Tax Act*. Such a notice is referred to as a "Requirement to Pay". The Board will comply with Requirements to Pay.

EFFECTIVE DATE: July 13, 2005
APPLICATION: Benefits, including retroactive awards of benefits, payable under the *Workers Compensation Act* on or after July 13, 2005.

#48.30 Worker Not Supporting Dependants

Where a worker is not supporting the worker's wife or husband and the worker's children and they are likely to be a charge upon the municipality where they reside, or where an order has been made against the worker by a court of competent jurisdiction for the support or maintenance of the worker's wife, husband or family, the Board may divert such compensation in whole or in part from the worker for the benefit of the worker's wife, husband or children. (1)

As the administration and payment of social assistance allowances is now a responsibility of the Provincial Government, a spouse or children not being supported by a worker are unlikely to become a charge on the municipality where they reside. Where, however, a request is received to divert compensation payments under the authority of Section 98(4), it must be supported by a Court Order. An exception might occur where, due to some unusual, unforeseen circumstances, the worker's spouse or children are in fact likely to become a charge on a municipality where they reside.

Where compensation is being diverted under this provision, any Consumer Price Index adjustments are apportioned between the payment made to the worker and the diverted payment.

The Board will comply with Notices of Attachment issued under Sections 8 and 9 of the *Family Maintenance Enforcement Act*.

#48.40 Overpayments/Money Owed to the Board

Section 15 provides an exception to its general prohibition of assignments, charges or attachments of compensation benefits in respect of "money owing to the accident fund". The Board may therefore deduct from compensation benefits the amount of money owed to it by the person entitled to receive them.

A claimant or employer may owe money to the Board in several ways. They may be paid more compensation benefits than they are entitled to as a result of an administrative error, a decision outside the statutory authority of the Board, or fraud or misrepresentation. (See #48.41.) They may incur liability for the repair or replacement of Board property which they damage. An employer or independent operator may fail to pay assessments owed to the Board.

Assessments owing by a limited company may be deducted from compensation payments made to the sole principal of that company or, where there is more than one principal, from payments made to a principal who is personally responsible for the non-payment of assessments. (2) This also applies to situations involving personal optional protection premiums owing.

#48.41 When Does an Overpayment of Compensation Occur?

An overpayment is any money paid out by the Board to a payee as a result of an administrative error, fraud or misrepresentation by the worker, or where the decision was not one within the statutory authority of the Board. Administrative errors are mechanical, mathematical, or an error in implementing a decision on a claim, and similar types of errors. They do not include decisions made regarding entitlement. An overpayment may also be incurred by a doctor, qualified practitioner, or an institution following the incorrect payment of a health care benefit account by the Board.

A decision regarding entitlement which is modified or reversed by a later decision does not result in an overpayment. These are referred to as "Decisional Errors" and include errors of policy. They include situations where new information is later received which initiates a judgment change in the original decision. They can also include situations where information was available but overlooked, or a missed wage rate change.

Decisional errors involving actions outside the statutory authority of the Board or due to fraud or misrepresentation are corrected retroactively to the date of the original decision, and result in an overpayment.

Board policy also does not require the initiation of recovery procedures for overpayments under $50.00 as long as there is no evidence of fraud or misrepresentation. All overpayments, irrespective of the amount, are referred to the Board's Legal Services Division where fraud or misrepresentation is indicated.

EFFECTIVE DATE: October 1, 2007 – Revised to remove reference to computer errors.

HISTORY March 3, 2003 (as to deletion of cross-references to payments to children on fatal claims, interim adjudications and appeals)

APPLICATION: Applies on or after October 1, 2007

#48.42 Recovery Procedures for Overpayments

If, at the time of the discovery of the overpayment, payments are still being made on the claim, the amount of any overpayment will be recovered from those payments. The Board officer will as far as possible do this in a manner which causes the least hardship to the worker. Normally, the Board officer will recover the amount owing by instalments. If payments of the claim are terminated by the time the overpayment is discovered or before full recovery can be obtained, the procedures outlined below are followed. However, if a request for a review by the Review Division or an appeal to the Workers' Compensation Appeal Tribunal against the overpayment is lodged, re-collection procedures are as outlined in policy item #48.46.

1. The Vocational Rehabilitation Services and Claims Departments will conduct the initial collection procedure which will include the Board officer making personal contact with the claimant in addition to sending two letters, one immediately and one 30 days later. For overpayments in excess of $500, the second letter advises that unpaid accounts will be turned over to the Board's Collections Section.

2. When the overpayment is 70 days overdue it will be sent to the Board's Collections Section. Unless there is evidence of fraud or misrepresentation, claims for overpayments under $500 are not sent to Collections.

3. A letter will be sent to the claimant by a Collections Officer at the 70-day overdue date indicating that the overpayment has been transferred to the Board's Collections Section and suggesting that payment be made within a month in order to avoid possible legal action. This letter

will make it clear that the Board is serious about collecting the overpayment.

4. If payment is not received within 30 days, or a reasonable payment plan arranged, the Collections Officer will attempt to make telephone contact with the claimant or pay a personal visit.

5. If this does not result in positive arrangements for payment, a final, more strongly worded letter will be sent. An asset search will be conducted and if there is a reasonable expectation that money is collectible, the account will be turned over to the Board's Legal Services Division for attention and action. The result of this action could be the seizing of assets or garnisheeing wages.

Policy item #50.00 sets out the procedures regarding the crediting of interest to retroactive wage-loss and pension payments. In the case of claims overpayments, interest charges only apply to amounts due where the overpayment is the result of fraud, misrepresentation or the withholding of information by the worker. Interest is not charged on overpayments that result from the correction of an error. The charging of interest on an overpayment must be approved by a Manager or a Director.

In the case of doctors and other health care benefit payees, overpayments are handled by the Board by making a deletion from future payments. There is no attempt by the Board to obtain the recovery of such an overpayment from a worker who received the health care benefits unless the costs of the health care benefits were paid directly to the worker.

EFFECTIVE DATE: March 3, 2003 (as to references to review, the Review Division and the Workers' Compensation Appeal Tribunal)

APPLICATION: Not applicable.

#48.43 Recovery of Overpayments on Reopenings or New Claims

If there is an outstanding overpayment made to a worker on a claim and that claim is reopened or a new claim for the same worker is established, the overpayment will be recovered from that worker. Normally, this will take place following contact with the worker to determine the manner in which the overpayment is to be recovered, either in full from the first payment of wage loss, or where the overpayment is a considerable sum of money, at a reasonable amount every two weeks during the period of disability. Every attempt will be made to recover the full amount of the overpayment.

Where there is an outstanding overpayment to either the worker or the employer and the claim is reopened or a new claim established, and if the worker is still employed by the same employer and they continue full salary, the overpayment will be recovered in full from that employer before subsequent wage loss is paid to them. The employer will be notified that this process is taking place. No recoveries are made from workers for overpayments made to employers.

Subject to the exception referred to in the preceding paragraph, the recovery of overpayments will be made only from those to whom the overpayment is made.

The general law of bankruptcy releases a bankrupt from all claims provable in bankruptcy upon discharge from bankruptcy. Therefore, where an overpayment has been incurred prior to the bankruptcy date, the Board does not take legal proceedings against the discharged bankrupt to recover the overpayment. Should a subsequent claim be submitted or the claim reopened, no attempt to recover such an overpayment is made.

#48.44 Deduction of Overpayments from Pensions

Where a worker is entitled to a permanent partial disability award, attempts are made to recover the overpayment prior to establishing the award. Whenever possible, the full amount will be recovered direct from the worker. Where recovery is not made prior to the payment of the award, the recovery may be made from the award itself either from the initial payment or on the basis of a pension adjustment as follows:

(a) non-payment of the full pension for a fixed term;

(b) a partial reduction of the pension for a fixed term;

(c) a partial reduction of the pension for life.

In the case of a large overpayment and/or a small pension, it is also possible that the capitalization of the full pension may be required to offset the overpayment.

Where a previous pension award has been made and the overpayment is on a subsequent claim, the Board does not usually elect to recover the overpayment from the prior pension award. This is an option that is only used as a last resort. The choice is first given to the worker as to how she or he wishes to repay the overpayment on the understanding that the Board would prefer not to interfere with the ongoing pension.

Where a pension has been suspended for the purpose of paying off an amount owing to the Board, the claimant will, every six months, be sent a statement showing the results of any changes in the pension amount because of Consumer Price Index adjustments, the amounts credited to the claimant's account as a result of the suspension, and the amount still owing.

Pensions to workers and dependants are paid to the end of each calendar month. Should a worker or dependant die during the month for which a full month's payment has been made, no deduction is made nor is any overpayment declared.

#48.45 Deduction of Overpayments from Rehabilitation Payments

An overpayment may be recovered from a rehabilitation assistance payment at the discretion of the Rehabilitation Consultant in consultation with the Claims Adjudicator or Claims Officer. Every attempt is, however, made by the Board to have the claimant make arrangements to repay the overpayment in some other method rather than reduce a rehabilitation payment. Recovery from a rehabilitation payment would only occur under exceptional circumstances.

#48.46 Reviews and Appeals on Overpayments

A request for a review by the Review Division may be made on the question of whether the claimant owes money to the Board and, if so, the amount owing. However, no such request may be made on the question of whether the Board should recover the overpayment or not, and on the manner of any recovery. Board policy requires that if an overpayment is being reviewed or appealed, procedures to recover the overpayment from the worker will be suspended pending the decision by the Review Division or the Workers' Compensation Appeal Tribunal. However, if a new claim is submitted, or a claim other than the one on which the request for review by the Review Division or the appeal to the Workers' Compensation Appeal Tribunal is recorded is reopened, recoveries of the overpayment may be made from any benefit entitlements that accrue. The Board officer will of course still be permitted to exercise discretion as to the amount and the periodic nature of the recovery.

EFFECTIVE DATE: March 3, 2003 (as to references to the Review Division and the Workers' Compensation Appeal Tribunal)

APPLICATION: Not applicable.

#48.47 Waiver of Overpayment Recoveries

Other than the exceptions listed in #48.41, it is the Board's position that recoveries should be made when an overpayment occurs. As such, it is expected that requests to waive recovery should be rare and must clearly meet policy criteria.

Board policy regarding the waiver of recovery procedures for overpayments provides for the following:

> The President, Vice-President, Compensation Services Division (or Directors for overpayments under $1,000) will have discretionary authority to waive recovery procedures for overpayments where:

1. in their judgment, severe financial hardship would result (it is not considered that amounts under $1,000 should be deemed as meeting this requirement); or

2. it is considered unreasonable or inadvisable to proceed with recovery.

In no case will recovery be waived if there was fraud or misrepresentation. Approval to waive recovery, when granted, does not constitute forgiveness of the debt. In some instances, at the discretion of the Vice-President (or Director for waivers under $1,000), a recovery waiver may be granted even though a pension is being paid or will be paid. Should a further claim be recorded or a later reopening accepted where a prior waiver has been approved, the question of initiating recoveries must first be discussed with the Vice-President or Director who approved the waiver.

#48.48 Unpaid Assessments

Unpaid and overdue assessments are treated in the same manner as overpayments if a claim is later received from an employer or principal of the limited company responsible for the debt or an independent operator who has purchased but not fully paid for personal optional protection coverage. If, at the time of the claim, the claimant is a worker for another company or organization, the decision whether or not to recover the overdue assessment from benefit entitlements can only be made by the Manager, Collections, or a Claims Director or a delegate. Recoveries will not be made from widows, widowers or dependants where the claim is the result of a fatality and the worker was employed with an employer other than the employer owing the assessments.

#48.50 Payment to Widow or Widower Free from Debts of Deceased

Any compensation owing or accrued to a worker or pensioner for a period not exceeding three months before death may, at the discretion of the Board, be paid to a widow, widower, or a person who takes charge of the funeral arrangements, free from debts of the deceased. (3)

#49.00 INCAPACITY OF A CLAIMANT

Under Section 12 of the *Act*, "A worker under the age of 19 years is sui juris for the purpose of this Part, and no other person has a cause of action or right to compensation for the personal injury or disablement except as expressly provided in this Part."

An exception is made by Section 35(1) of the *Act* which provides in part that ". . . in the case of minors or persons of unsound mind who the board considers are

incapable of managing their own affairs, . . .” payments of compensation “. . . may be made to the persons that the board thinks are best qualified in all the circumstances to administer the payments, whether or not the person to whom the payment is made is the legal guardian of the person in respect of whom the payment is being made.”

Compensation benefits due to a worker, where a public trustee has been appointed, will be issued in the name of the worker but sent to the public trustee.

#49.10 Worker Receiving Custodial Care in Hospital

Section 35(5) provides that “Where a worker is receiving custodial care in a hospital or elsewhere, periodical payments of compensation due to the worker … may be paid to or for the benefit of

(a) the worker to the extent the worker is able to make use of the money for his or her personal needs or is able to manage his or her own affairs; or

(b) any person who is dependent on the worker for support, or in a case of temporary disability of the worker may be

(c) applied to the maintenance of a home to which the worker is likely to return on his or her recovery; or

(d) accumulated by the board for payment to the worker on his or her recovery,

or in a case of permanent disability may be applied toward the cost of the worker's maintenance, but, in that case and where the worker is conscious, there must be paid to, or for the use of, the worker a comfort allowance of at least . . .” the amount set out below out of each periodic payment.

July 1, 2000	—	December 31, 2000	$175.01
January 1, 2001	—	June 30, 2001	178.44
July 1, 2001	—	December 31, 2001	181.24
January 1, 2002	—	June 30, 2002	181.86

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

“Subsection (5) applies, regardless of the date of the injury.” (4)

#49.11 Meaning of Custodial Care in Hospital or Elsewhere in Section 35(5)

Section 35(5) applies where a worker is receiving “custodial care in a hospital or elsewhere”.

"Custodial care" requires that the worker be undergoing a voluntary or involuntary stay in, and be receiving care from, a hospital or other similar institution. Only long-term or permanent residence in a hospital or similar institution could amount to "custodial care". It does not cover periodic stays in hospital which a worker might have to undergo for the purpose of surgery or other treatment.

A worker is not considered to be receiving "custodial care" when confined to prison or other corrective institution. While the worker might be said to be in involuntary custody, it is not felt that the worker is undergoing "care" for the purpose of the section. The case would be different if the prison or corrective institution were also a hospital. The Board has authority under Section 98(3) of the Act to discontinue the compensation of workers confined to prison. (5)

#49.12 Nature of the Board's Authority under Section 35(5)

Section 35(5) clearly confers a discretionary power on the Board. In exercising this discretion, the Board is free to choose any of the applicable alternatives listed in Section 35(5) without regard to the order in which they are set out. There is no obligation on the Board to give any priority to any of the alternative choices set out in the section.

This does not mean that, in exercising its discretion under Section 35(5), the Board cannot set its own priorities for the application of the various alternatives. The necessity to set guidelines for Board staff in their administration of this section, as a matter of practice, may require that the Board lay down some order of priority. This will appear from the guidelines set out below in relation to the sub-paragraphs of Section 35(5).

#49.13 Application of Section 35(5) in Cases of Temporary Disability

In the case of a worker entitled to temporary disability payments who is receiving custodial care in a hospital or elsewhere, the Board may take any of the alternative courses of action set out in paragraphs (a) to (d) of Section 35(5). Guidelines for applying these alternatives are set out below in paragraphs 1. to 4.

1. **Worker able to use money for personal needs or to manage personal affairs**.

   The Board may pay the compensation to the "worker to the extent the worker is able to make use of the money for his or her personal needs or is able to manage his or her own affairs." Priority should normally be given to this alternative. To the extent able, the worker should make a personal choice as to how much of the compensation payment

to spend on personal needs, how much to contribute to the home and family, and how much to save.

This provision requires that a judgment be made on an individual basis as to the amount which the worker is able to use or manage for personal needs. This may be none, all, or part only of the worker's compensation payment, since payment is to be made to the worker only to the "extent" that the worker is capable of using or managing it.

A distinction is drawn between the amount which the worker can use for personal needs and the amount that he or she can manage. A worker may be capable of managing an amount which is greater than what can be used for personal needs. On the other hand, there may be the capacity to handle small amounts of money to purchase personal comforts without the worker having any capacity to further manage personal affairs. Where there is an entitlement to temporary disability payments, these are to be paid in an amount the worker is capable of using for personal needs or in an amount the worker is capable of managing, whichever is greater.

Any balance remaining after payment is made to the worker will be applied under alternatives 2. to 4. below.

2. **Person dependent on the worker for support**.

The Board may pay the compensation to "any person who is dependent on the worker for support". Any balance remaining after payment has been made to the worker under alternative 1. will normally be paid to any dependants living with, and being maintained by, the worker.

Where a person who is dependent on the worker for support lives separate from the worker, payments will be made to the dependant only to the extent that he or she was maintained by the worker. Therefore, if the worker was making a regular payment to the dependant, whether voluntarily or by virtue of a separation agreement or court order, the amount of that payment will be paid to the dependant by the Board. Where the worker was making no regular payments or not complying with a separation agreement or court order, judgment must be made as to the amount that would have paid to the dependant had the worker been capable of managing personal affairs.

Where compensation is payable to the worker's children under this provision, it may be paid to a foster-parent or home or other person or institution looking after them.

Where compensation is paid under alternative 1. on the basis that the worker is capable of managing his or her affairs but does not support the worker's wife or husband and the worker's children, the Board may be able to divert all or part of the worker's compensation to the worker's wife, husband or children under Section 98(4) of the Act. (6)

3. **Maintenance of a home**.

The Board may apply the worker's compensation payment to the "maintenance of a home to which the worker is likely to return on his recovery". Where payments are made to the worker under alternative 1. above on the basis that the worker can manage personal affairs or are made to the dependants living with the worker under alternative 2., it is expected that the worker or dependants will use the money to maintain their home. Alternative 3. should only be of relevance when the worker is incapable of managing the property alone and there are no dependants living under the same roof.

Payments for the maintenance of the worker's home should normally be made to the person who is managing the property on the worker's behalf. The Board should not normally undertake the management of a worker's property.

4. **Accumulation of balance**.

Temporary disability payments may be "accumulated by the board for payment to the worker on his recovery". Any balance remaining after payments have been made under alternatives 1. to 3. set out above should be accumulated until the worker has recovered the capacity to manage personal affairs. The accumulations should then be paid to the worker either as a lump sum or, if this is in the worker's best interests, by instalments over a period of time.

#49.14 Application of Section 35(5) in Cases of Permanent Disability

In the case of a worker entitled to permanent disability payments who is receiving custodial care in a hospital or elsewhere, the Board may take any of the alternative courses of action set out in paragraphs (a) and (b) and the final paragraph of Section 35(5).

The guidelines for dealing with these cases are set out below.

1. **Worker able to use money for personal needs.**

   Under paragraph (a) of Section 35(5), permanent disability payments will in the first place be paid to the worker to the extent that the worker is capable of using them for personal needs. Where a worker is capable of handling greater sums than required for personal needs, paragraph (a) of Section 35(5) authorizes the Board to pay these greater sums to the worker and this is the practice of the Board in the case of temporary disability. However, in the case of permanent disability, the exercise of this authority would conflict with the object of the section to prevent the accumulation of estates. It is not therefore the Board's practice to pay more to the permanently disabled worker than required for personal needs.

2. **Person dependent upon the worker for support.**

   Any balance remaining after the application of alternative 1. above will be applied for the benefit of any dependants of the worker according to the same principles as for temporary disability.

3. **Maintenance costs.**

   Any balance remaining after the application of alternatives 1. and 2. above will be applied toward the cost of the worker's maintenance. This applies to the full cost of custodial care, not just the value of the claimant's room and board. It only applies when the Board is paying the cost of maintenance as part of the costs of a compensation claim.

Where a worker is conscious and compensation is being applied toward the cost of maintenance, the worker must receive a comfort allowance of a minimum amount which is subject to Consumer Price Index adjustments. The amount of this minimum is set out in #49.10. Comfort allowance is interpreted to mean the monies payable to the worker under alternative 1. above which the worker is able to use for personal needs. The result is that where the worker is conscious, the minimum amount payable for personal needs is the amount set out in #49.10.

Any balance remaining after payment of the cost of maintenance will be paid to the worker to the extent the worker is able to manage personal affairs. To the extent the worker is not able, it will be paid to the person who is best qualified to administer it under the terms of Section 35(1) of the Act.

#49.15 Application of Section 35(5) on a Change of Circumstances

A situation may arise where the compensation of a worker receiving custodial care is being applied to the cost of maintenance, but the worker becomes able to leave the hospital and live at home. Section 35(5) would then cease to have any

application so that it would be necessary to resume payment of the worker's disability pension. However, the worker would not be entitled to receive the payments previously applied to the cost of maintenance. If, following departure from custodial care, the worker remains incapable of handling personal affairs, consideration should be given to the application of Section 35(1).

It may also happen that what was initially thought to be a temporary disability might turn out to be permanent. As soon as this is definitely known, consideration should be given to using any part of the periodical payments not required for the worker's personal needs or dependants' needs, for the cost of maintenance. This would only apply to future compensation payments.

49.16 Administration of Section 35(5)

Decisions on the application of Section 35(5) are to be made by the Claims Adjudicator in the case of temporary disability and by the Disability Awards Officer or Adjudicator in Disability Awards in the case of permanent disability. The information required to make the decision, where not already on file, will be obtained by the Claims Adjudicator, Disability Awards Officer or Adjudicator in Disability Awards, or, where appropriate, by a Rehabilitation Consultant or Board Medical Advisor.

#49.17 Date of Commencement

The guidelines set out in #49.11-16 apply to any claim where a worker is receiving custodial care on July 6, 1977, except that in the case of a permanently disabled worker who is wholly or partially capable of managing personal affairs, periodical payments will continue to be made as prior to that date. In regard to cases arising after July 6, 1977, Section 35(5) and the guidelines should be considered as soon as it comes to the attention of the Claims Adjudicator, Disability Awards Officer or Adjudicator in Disability Awards that a worker will be undergoing custodial care in a hospital or elsewhere. As far as is reasonably practical, they should be applied from the date when the custodial care commences.

#49.20 Imprisonment of Worker

This policy deals with the application of Section 98(3). In considering the payment of compensation under this policy, regard must be given the individual circumstances of the case.

Section 98(3) of the Act provides:

> Where it is found that a worker is confined to jail or prison, the Board may cancel, withhold or suspend the payment of compensation for the period it considers advisable. Where compensation is withheld or suspended, the

> Board may pay the compensation or any portion of it to the worker's wife, husband or children, or to a trustee appointed by the Board, who must expend it for the benefit of the worker, the worker's wife, husband or children.

Section 98(3) applies where it is determined that a worker who is receiving benefits is subsequently incarcerated in any place used to confine persons in the course of the administration of the criminal justice system. The section does not apply to situations where a worker is injured while incarcerated.

In applying Section 98(3), the following definitions apply:

> Cancel: to terminate compensation payments for the period considered advisable - the payments otherwise payable during the period of cancellation are permanently lost to the worker - the payments cannot be redirected.
>
> Suspend: to temporarily terminate compensation payments - the payments are not accumulated by the Board for the worker but may be redirected during the temporary stop in accordance with Section 98(3).
>
> Withhold: to temporarily hold back compensation payments - the payments may be accumulated by the Board and paid to the worker upon release from prison, or may be redirected during the temporary hold back in accordance with Section 98(3).

Vocational rehabilitation benefits will be cancelled during the period of incarceration while the worker is unable to participate in the rehabilitation program.

Health care benefits will generally continue to be paid during incarceration.

Wage loss benefits (Sections 29 and 30) will be suspended during the period of incarceration as there is considered to be no loss of earnings during incarceration. These benefits may be paid, in whole or in part, to the worker's wife, husband or children, or to a trustee appointed by the Board to expend for the benefit of the worker, the worker's wife, husband, or children. If not redirected, these benefits are permanently lost during the period of incarceration.

Functional impairment pension benefits (Sections 22 and 23(1)) will either continue to be paid or be withheld during the period of incarceration. If withheld, these benefits may be paid, in whole or in part, to the worker's wife, husband or children, or to a trustee appointed by the Board to expend for the benefit of the worker, the worker's wife, husband, or children. Benefits neither paid to the worker nor redirected will be paid to the worker on release.

Loss of earnings pension benefits (Section 23(3)) will be suspended during the period of incarceration. These benefits may be paid, in whole or in part, to the

worker's wife, husband or children, or to a trustee appointed by the Board to expend for the benefit of the worker, the worker's wife, husband or children. If not redirected, these benefits are permanently lost during the period of incarceration; however, the worker will be entitled, during the period of confinement, to the Section 23(1) award the worker would have been granted had there been no Section 23(3) consideration.

Confinement under Section 98(3) only includes those circumstances where the worker is prevented from seeking or obtaining employment for regular wages under an employee/employer relationship. Thus, ongoing entitlement to benefits will be determined once the worker is released on day parole and is no longer considered to be "confined" to jail or prison.

When an incarcerated worker whose benefits have been cancelled, suspended or withheld becomes eligible to participate in a work release program, but is unable to do so because of the effects of a work caused disability accepted under the claim, compensation benefits may be reinstated from that point.

The power to redirect payments to dependants is exercised if the worker was supporting the worker's wife, husband or children prior to the imprisonment. All, or a portion of the compensation, is paid to them or a trustee, the amount depending on the number of dependants and their needs. If the worker was not supporting them, the power is not exercised unless there is a court order against the worker, in which case the amount provided for in the order will be paid. The power to pay the compensation to a trustee for the benefit of the worker depends on the reasonable needs of the worker while incarcerated.

#49.30 PAYMENT OF PUBLIC TRUSTEE AND COMMITTEE FEES

The Board pays the fees charged to a worker by the Public Trustee or Committee for managing the worker's entire estate when the following conditions are met:

1. The worker is incapable of managing his or her own affairs and the Public Trustee or Committee administers the worker's estate;

2. The worker's incapacity to manage his or her own affairs results from a compensable injury or disease; and

3. The Public Trustee or Committee is appointed to manage the worker's affairs under the *Patients Property Act* or the *Public Trustee Act*, or equivalent statute.

The Board will pay the Public Trustee and Committee fees in accordance with the fee schedule established by the Public Trustee. Fees may include the

account review fee paid to the Public Trustee by Committees and the accountant's fees for preparing the account summaries.

The Board will pay the Committee fees after the Public Trustee has approved the accounts.

#50.00 INTEREST

With respect to compensation matters, the *Act* provides express entitlement to interest only in the situations covered by sections 19(2)(c) and 258. In these situations, the Board will pay interest as provided for in the *Act* (see policy items #55.62 and #100.83).

The Board has discretion to pay interest in situations other than those expressly provided for in the *Act*. In these situations, interest may be paid subject to the following conditions:

- The retroactive payment is:
    - To a worker or employer in respect of a wage loss payment provided under sections 29 and 30 of the *Act.*
    - To a worker or employer in respect of a permanent disability lump sum payment provided under sections 22 and 23 of the *Act.*
    - To a dependant of a deceased worker in respect of a payment provided under section 17 of the *Act.*
- It has been determined that there was a blatant Board error that necessitated the retroactive payment. For an error to be "blatant" it must be an obvious and overriding error. For example, the error must be one that had the Board officer known that he or she was making the error at the time, it would have caused the officer to change the course of reasoning and the outcome. A "blatant" error cannot be characterized as an understandable error based on misjudgment. Rather, it describes a glaring error that no reasonable person should make.
- Interest will be calculated from the first day of the month following the commencement date of the retroactive benefit and up to the end of the month preceding the decision date. Notwithstanding, in no case will interest accrue for a period greater than twenty years.

In all cases where a decision to award interest is made, the Board will pay simple interest at a rate equal to the prime lending rate of the banker to the government (i.e., the CIBC). During the first 6 months of a year interest must be calculated at the interest rate as at January 1. During the last 6 months of a year interest must be calculated at the interest rate as at July 1.

For practical reasons, certain mathematical approximations may be used in the calculations.

The rate of interest provided in this policy will also be used in the calculation of overpayments as outlined in policy item #48.42.

EFFECTIVE DATE: March 1, 2006

APPLICATION: Applies to all decisions, including appellate decisions, made on or after March 1, 2006.

#50.10 Position Prior to May 7, 1984

Prior to January 24, 1979, the Board's practice was not to pay interest at all on wage-loss or pension payments. On that date, a practice of paying interest on pension awards only was initiated which was identical to the practice set out above save in two respects. No interest was payable if the condition arose less than three years prior to the decision to make the award and the interest payable was compounded monthly at a period rate of 0.4166% on a periodic deposit formula. Effective January 1, 1980, this rate was changed to 0.50%. The three year period was shortened to one year on April 17, 1980. On April 30, 1980, it was decided that the rate of interest should be reviewed every year and be identical with the average rate of return on the Board's total investment portfolio for the preceding year. In accordance with that practice, the rate was on that date changed to 0.66%, the average return on the Board's investment portfolio in 1979. On November 26, 1981, the above rules were extended to wage-loss benefits.

#51.00 CONSUMER PRICE INDEX

Section 25(1) of the Act provides that "As of the first day of July in each year the board must determine a ratio by comparing the consumer price index for April in that year with the consumer price index for October in the preceding year; and as of each first day of January, the board must determine a similar ratio by comparing the consumer price index for October in the preceding year with the consumer price index for April in the preceding year." The ratios which the Board has determined under this provision are set out below.

Date	Ratio
July 1, 2000	1.00807175
January 1, 2001	1.01957295
July 1, 2001	1.01570681
January 1, 2002	1.00343643

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

"Consumer Price Index" means the Consumer Price Index for Canada published by Statistics Canada under the *Statistics Act* (Canada).

Prior to July 1, 1974, the *Act* provided a different method of making Consumer Price Index adjustments. (7)

Authority to approve adjustments under Section 25 has been assigned to the President.

Authority has also been assigned to the President to adjust the following amounts to reflect changes in the Consumer Price Index, using the formula set out in the applicable item of the manual:

Maximum and Minimum Disfigurement Amount		#43.20
Clothing Allowances		#79.00
Personal Care Allowances		#80.20
Independence and Home Maintenance Allowance		#81.00
Transportation Allowance		#82.20
Subsistence Allowances:	(a) Meals	#83.20
	(b) Non-Residence Accommodation	#83.20
Transfer of Costs		#114.11

#51.10 Existing Periodical Payments

As of July 1 and January 1 in each year, the Board must, by applying the ratio determined under #51.00, adjust all periodic payments then being paid or payable in respect of every injury or death occurring, and every disablement from occupational disease sustained, prior to six months before the date the adjustment is being made. (8)

Where periodic payments of compensation are commenced or recommenced in respect of an injury, death, or disablement from occupational disease sustained more than six months prior to the commencement or recommencement, the level of compensation is determined as if the payments had been continuously made from the date of injury, death, or disablement from occupational disease. (9) This means that if payments on a claim are commenced or recommenced more than six months after the injury, the claimant will receive the benefit of any Consumer Price Index increases occurring in the intermediary period which he or she would have received if continuously paid since the date of injury.

Where a worker in receipt of a pension dies as a result of the pensionable disability and dependant's benefits are payable, no Consumer Price Index adjustment is computed in the six-month period following the date of death.

#51.11 Reopening Claims

Where a claim is reopened on the basis of the claimant's earnings at the time of the original injury, the claimant will receive the benefit of any Consumer Price Index adjustments occurring between the injury and the reopening which would have been received if continuously paid since the date of injury. However, where the claim is reopened after three years on the basis of the claimant's earnings at the time of the reopening, the date of the reopening is treated as the date of the injury. No Consumer Price Index adjustments are applied in such a case until after six months has elapsed since the reopening. The Consumer Price Index adjustment will then apply to the next change that occurs in the ensuing six-month period. (10)

#51.12 Injury, Death or Disablement Occurring Prior to July 1, 1974

Section 25 applies regardless of the date of the injury, death, or disablement from occupational disease.

However, the requirement that six months elapse between the date of a death and the first Consumer Price Index adjustment has been limited to deaths occurring on or after July 1, 1974. The adjustment which took place on July 1, 1974, was applied in the case of deaths occurring on or after January 1, 1974, and before July 1, 1974, as well as to deaths occurring prior to January 1, 1974.

In the case of deaths prior to July 1, 1974, the Act prior to that date had since January 1, 1966 made provision for Consumer Price Index adjustment of pensions payable to dependent spouses and children. No such adjustments were applicable to pensions payable to other dependants of the deceased worker, for example, parents. (11) This meant that the pension base to which Consumer Price Index adjustments were applied on and after July 1, 1974, was smaller for such dependants than for spouses and children. This situation is remedied by Section 27 which provides that:

> "Where dependants are receiving or are eligible to receive periodic payments in respect of the death of a worker occurring prior to July 1, 1974, and in respect of which payments there was no provision prior to that date for increases according to the consumer price index, those periodical payments must be adjusted as of August 1, 1975, so that after that date the periodical payments will be at the same rate as if the provisions of the Act relating to increases according to the consumer price index between January 1, 1966 and July 1, 1974 had been applicable."

Non-resident dependants whose pensions were adjusted annually to achieve "a like degree of comfort, etc." (12) are considered to have received Consumer Price Index adjustments and there is no need to recalculate their claims under Section 27.

#51.13 Partially Commuted Pensions

Where a worker is receiving a permanent total disability award at the statutory minimum, and there was a commutation prior to November 30, 1973, the worker receives future cost of living increases based on the full statutory minimum, less the dollar amount of the commutation. If there is, or has been, a commutation since November 30, 1973, future cost of living increases are based on the remaining pension benefits after the commutation.

#51.20 Dollar Amounts in the Workers Compensation Act

Each dollar amount mentioned in the Act in any context whatsoever is adjusted by the Board on January 1 and July 1 in each year by applying the ratio determined under #51.00, and on the Board making the adjustments, all sections containing those dollar amounts are deemed to be amended accordingly. (13) This provision does not apply to the figures referred to in #39.61, the maximum wage rate and other figures referred to in #69.00.

Section 28 provides that "There must be published in the Gazette amendments to the Act resulting from changes in the consumer price index."

NOTES

(1) S.98(4)
(2) See 70:20:80 Assessment Policy Manual
(3) S.35(4)
(4) S.35(6)
(5) See #49.20
(6) See #48.30
(7) S.18 and S.25, prior to repeal by Workmen's Compensation Amendment Act, 1974
(8) S.25(2)
(9) S.25(3)
(10) See #70.20
(11) S.18, prior to repeal by Workmen's Compensation Amendment Act, 1974
(12) See #62.20
(13) S.25(4)

CHAPTER 8

COMPENSATION ON THE DEATH OF A WORKER

#52.00 INTRODUCTION

Compensation is payable as the result of a death where ". . . death arising out of and in the course of the employment is caused to a worker . . ." (1) or death is caused by an occupational disease which is due to the nature of any employment in which the worker was employed. (2) The compensation is payable to surviving dependants of the deceased or in some cases to non-dependent relatives having a reasonable expectation of pecuniary benefit from the continuation of the life of the deceased.

The compensation is normally based on the worker's average earnings prior to the death. However, adjustments are made to payments and to the dollar amounts in the *Act* according to changes in the Consumer Price Index. Where a worker in receipt of a pension dies as a result of the pensionable disability and dependant's benefits are payable, no Consumer Price Index adjustment is computed in the six-month period following the date of death. The meaning of "average earnings" is discussed in Chapter 9. Consumer Price Index adjustments are dealt with in Chapter 7.

#53.00 FUNERAL AND OTHER DEATH EXPENSES

Where compensation is payable as the result of the death of a worker or as the result of injury resulting in the death, an amount in respect of funeral and related expenses is paid in addition to any other compensation payable. The amount payable is set out below.

The employer of the worker is required to bear the cost of transporting the body to the nearest business premises where funeral services are provided, and if burial does not take place there any additional transportation may, up to the sum set out below, be paid by the Board.

	Funeral And Related Expenses	**Transportation of Body**
July 1, 2000 - December 31, 2000	$6,611.76	$1,044.60
January 1, 2001 - June 30, 2001	$6,741.17	$1,065.05
July 1, 2001 - December 31, 2001	$6,847.05	$1,081.78
January 1, 2002 - June 30, 2002	$6,870.58	$1,085.50

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

No action for an amount larger than that established by the above provisions lies in respect of the funeral, burial, or cremation of the worker or cemetery charges in connection with it. (3)

#53.10 Person to Whom Expenses are Paid

Payment is made to whoever appears to be the most eligible having regard to who has incurred the cost of funeral and other expenses, or who has undertaken to meet those payments. For example, if an employer, a union, or a distant relative has, perhaps by arrangement with the widow or widower, paid the undertaker before the claim has been adjudicated at the Board, the person who paid the bill may be reimbursed by paying the monies referred to in #53.00. If that person has paid a lesser sum than the figures there mentioned, there should be a reimbursement to the extent of the payment, and the balance paid to the widow or widower, or whoever else appears to be the most eligible person.

However, once the Board has paid out the monies referred to in #53.00, there can be no question thereafter of the Board considering claims by any other person for funeral expenses. For example, if an employer, a union, or a relative has paid the undertaker, but has not presented any claim to the Board until after the monies have been paid out to the widow or widower, such a person cannot subsequently be reimbursed directly by the Board by a deduction out of compensation benefits. If the other person wishes to be reimbursed out of compensation benefits, that person must make the request to the widow, widower or other person receiving those benefits.

#54.00 MEANING OF "DEPENDANT"

The term “dependant” is defined in Section 1 of the Act to mean “. . . a member of the family of a worker who was wholly or partly dependent on the worker's earnings at the time of the worker's death, or who but for the incapacity due to the accident would have been so dependent, . . .”

The members of a worker’s family means “. . . wife, husband, father, mother, grandfather, grandmother, stepfather, stepmother, son, daughter, grandson, granddaughter, stepson, stepdaughter, brother, sister, half-brother and half-sister and a person who stood in loco parentis to the worker or to whom the worker stood in loco parentis, whether related to the worker by consanguinity or not;”. (4) A former husband or wife cannot be a member of the worker’s family and therefore cannot be the worker’s dependant.

Dependency does not exist simply because the claimant had the legal status of husband, wife, child, parent, etc. There must be evidence that, at the time of the

worker's death, the claimant was actually dependent on the deceased's earnings. Normally, this means that there must be evidence of sufficient actual support having been provided by the deceased to the claimant. This is so even though the deceased was, at the time of death, subject to a court order to maintain the claimant and the claimant was in need of support. Except in respect of the provision discussed in #61.00, a reasonable expectation of pecuniary benefit from the continuation of the life of the deceased is not itself sufficient to constitute dependency.

The above principles also apply where the claimant is a child. In the case of a child who was unborn at the date of the worker's death, once paternity is established, the fact that the deceased worker would have been under an obligation to support the child is evidence to warrant an inference that that person would have supported the child, and should be accepted as proof of dependency unless it is controverted by evidence to the contrary. If it is found that the deceased worker was supporting the mother at the time of death, that is also evidence from which an inference may be drawn that that person would have supported the child.

Dependency is determined at the date of death. Changes of circumstances after the death, for instance, the marriage of a child, do not affect the status of a person as a dependant.

#54.10 Presumptions of Dependency

For deaths occurring on or after July 1, 1974, Section 17(7) of the Act provides that "Where 2 workers are married to each other and both are contributing to the support of a common household, each is deemed to be a dependant of the other." Section 17(8) provides that "Where 2 parents contribute to the support of a common household at which their children also reside, the children are deemed to be dependants of the parent whose death is compensable under this Part." The latter provision applies to children of the two parents, not to children of a former marriage of either parent living with them, but the two parents need not be married to each other.

An argument was made in one claim that Section 17(7) applied because, though the claimant and her husband had been living in separate residences at the date of his death, the claimant was contributing to the support of a common household, namely the household where her husband and children resided. Her contribution included visits to the premises, assistance with housework and financial contributions. This argument was not accepted.

It was concluded that there was no common household. For a common household to exist it is not necessary that there be a constant 24-hour-a-day presence by both parties in the house. There are obviously many reasons why

one party to a marriage would leave the house for different periods which would not affect the existence of the common household. However, this only applies when the absences are consistent with the normal continuation of the marriage. The common household will come to an end when there is some kind of separation of the parties which brings into question the continued existence of the marriage, for example, if one party deserts the other or, because of difficulties in the marital relationship, a separation agreement or court order comes into being. Nor could it be concluded that a prospect of reconciliation would make a difference. This might indicate a possibility of the common household again coming into existence at a future time, but did not alter the fact that there was no such household currently in existence.

#55.00 WIDOWS AND WIDOWERS DEATH ON OR AFTER JULY 1, 1974

Widows or widowers who were not dependent on the earnings of the deceased at the time of death are not entitled to compensation under the provisions set out below. They may, however, be entitled under the provisions set out in #61.00.

#55.10 Lump Sum Payment to Dependent Widows or Widowers

In addition to any other compensation provided, a dependent widow or widower in Canada to whom compensation is payable is entitled to a lump sum equal to the amount set out below. (5)

July 1, 2000	—	December 31, 2000	$1,952.80
January 1, 2001	—	June 30, 2001	1,991.02
July 1, 2001	—	December 31, 2001	2,022.29
January 1, 2002	—	June 30, 2002	2,029.24

If required, earlier figures may be obtained by contacting the Board.
Payment of this amount is made as soon as the claim is accepted.

#55.20 Dependent Spouse with Dependent Children

#55.21 Widow or Widower with Two or More Children

Where the dependants are a widow or widower and two or more children, a monthly payment is made of such sum as, when combined with Federal benefits payable to or for those dependants, equals the total of:

(a) the monthly rate of compensation that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability, (6) subject to the minimum set out in #55.26, and

(b) the amount set out below per month for each child beyond two in number. (7)

July 1, 2000	—	December 31, 2000	$253.77
January 1, 2001	—	June 30, 2001	258.74
July 1, 2001	—	December 31, 2001	262.80
January 1, 2002	—	June 30, 2002	263.70

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

For example, consider the case of a worker whose death occurred on January 1, 1986, and whose average earnings were $40,000 per annum. He leaves a dependent widow and three dependent children, who were entitled to Federal benefits.

A.	Federal benefits			
	C.P.P. pension for widow		=	273.35
	C.P.P. pension for children (3 x 91.06)		=	273.18
				546.53
	Total Federal benefits		=	546.53
B.	Monthly permanent total disability pension rate at date of death	75% x 40,000 / 12	=	2,500.00
C.	Additional child allowance under Section 17		=	170.92
D.	Total monthly benefits (B plus C)		=	2,670.92
	Total benefit entitlement (W.C.B. and C.P.P.)		=	2,670.92
E.	Total W.C.B. benefits (D less A)		=	2,124.39

#55.22 A Widow or Widower with One Child

Where the dependants are a widow or widower and one child, a monthly payment is made of such sum as, when combined with Federal benefits payable to or for those dependants, equals 85% of the monthly rate of compensation that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability, subject to the minimum set out in #55.26. (8)

In regard to the example given in #55.21, assume the deceased left only one dependent child.

A.	Federal benefits			
	C.P.P. pension for widow		=	273.35
	C.P.P. pension for child		=	91.06
				364.41
	Total Federal benefits		=	364.41
B.	Monthly permanent total disability pension rate at date of death	75% x $\frac{40,000}{12}$	=	2,500.00
C.	85% of permanent total disability pension rate (total monthly benefits)	85% x 2,500.00	=	2,125.00
	Total benefit entitlement (W.C.B. and C.P.P.)		=	2,125.00
D.	Total W.C.B. benefits (C less A)		=	1,760.59

#55.23 A Meaning of "Invalid"

“Invalid” is defined in Section 1 of the Act to mean “. . . physically or mentally incapable of earning”. This excludes a person who is disabled, but capable of earning. However, it is provided in Section 17(6) that “Where at the date of death a spouse is not an invalid, but is suffering from a disability that results in a substantial impairment of earning capacity, the board may, having regard to the degree of disability or the extent of impairment of earning capacity, pay the spouse a proportion of the compensation that would have been payable if the spouse had been an invalid.” A temporary invalidism or disability is not covered by these provisions.

#55.24 Meaning of "Federal Benefits"

“Federal benefits” means the benefits payable under the Canada Pension Plan and to which any dependants are entitled as a result of the death, together with any benefits to which the dependent spouse is or becomes entitled under the Canada Pension Plan as a result of having retired or reached retirement age. (9)

#55.25 Meaning of "Child" or "Children"

This is discussed in #59.10.

#55.26 A Minimum Amount of Average Earnings

The minimum allowances payable under #55.21-#55.22 are such allowances as would be payable if the allowances were calculated in respect of a deceased worker with average earnings equal to the amount set out below. (10)

July 1, 2000	—	December 31, 2000	$27,338.14
January 1, 2001	—	June 30, 2001	27,873.23
July 1, 2001	—	December 31, 2001	28,311.03
January 1, 2002	—	June 30, 2002	28,408.32

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

The minimum average earnings applicable to deaths occurring on or after January 1, 1986, and before July 1, 1986, is $18,411.71. If the average earnings of the worker referred to in the example in #55.21 were only $15,000.00 the monthly amount payable to his widow and three children would be as follows:

A.	Total Federal benefits (as in #55.21)		=	546.53
B.	Monthly permanent total disability pension rate at date of death	75% x $\frac{18,411.71}{12}$	=	1,150.73
C.	Additional child allowance under Section 17		=	170.92
D.	Total monthly benefits (B plus C)		=	1,321.65
	Total benefit entitlement (W.C.B. and C.P.P.)		=	1,321.65
E.	Total W.C.B. benefits (D less A)		=	775.12

#55.30 Dependent Spouse with No Children

#55.31 Widow or Widower 50 Years of Age or Over or Invalid

Where the dependant is a widow or widower who, at the date of death of the worker, is 50 years of age or over, or is an invalid spouse, a monthly payment of a sum that, when combined with Federal benefits payable to or for that dependant, equals 60% of the monthly rate of compensation that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability, but such monthly payments shall not be less than the minimum set out below. (11)

July 1, 2000	—	December 31, 2000	$820.02
January 1, 2001	—	June 30, 2001	836.07
July 1, 2001	—	December 31, 2001	849.20
January 1, 2002	—	June 30, 2002	852.12

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

For the definition of "invalid", see #55.23.

The minimum monthly payment is the actual minimum paid by the Board. It is not a minimum total benefits which incorporates Federal benefits. In the case of deaths occurring prior to June 26, 1975, the minimum set out above does not apply. However, the minimum average earnings referred to in #55.26 is applicable. (12)

The computation formula is the same as was described in #55.22, however, 60%, rather than 85%, of the deceased's projected permanent total disability pension is taken. "Federal benefits" has the meaning set out in #55.24.

#55.32 Non-Invalid Widow or Widower under 40 Years

Where the dependant at the date of the worker's death is a widow or widower who is not an invalid and is under the age of 40 years, and there are no dependent children, a capital sum equal to the amount set out below is payable. Of this, a first installment is payable immediately. The balance is payable at a time the Board determines; but the payment cannot, except at the request of the dependant, be delayed beyond six months after the date of death of the worker. (13) The amount of the first installment and the balance is also set out below.

			First Installment	**Balance**	**Total Amount**
July 1, 2000	—	December 31, 2000	$3,905.51	$35,148.88	$39,054.39
January 1, 2001	—	June 30, 2001	3,981.95	35,836.89	39,818.80
July 1, 2001	—	December 31, 2001	4,044.49	36,399.74	40,444.23
January 1, 2002	—	June 30, 2002	4,058.39	36,524.82	40,583.21

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

In exercising its discretion when to pay the balance, the Board does not seek to regulate the use of the money. But it does try to ensure that the surviving spouse has a good opportunity to make rational choices about its use.

The letter of decision accepting the claim will provide for the immediate payment of the first installment. Ordinarily, payment of the balance will be processed one month after this letter. That should normally provide a reasonable period for the spouse to consider how the money should be used before it arrives. But the

Rehabilitation Consultant may consider whether it should be sent earlier or later and make a recommendation on this to the Adjudicator. In no case must payment in full be delayed more than six months after the date of death.

#55.33 Non-Invalid Widow or Widower between 40 and 49 Years

Where the dependant is a widow or widower who is not an invalid and who, at the date of death of the worker, has reached the age of 40 years but not the age of 50 years, and there are no dependent children, a monthly sum calculated under Schedule C of the Act is paid. (14)

Schedule C provides for a monthly payment of the minimum amount set out in #55.31 plus the following proportion of the difference between that amount and the monthly payment that would be payable using the general formula set out in #55.31.

Schedule C

Age of Widow or Widower at Date of Death of Worker	**Proportion of Difference**
40	1/11
41	2/11
42	3/11
43	4/11
44	5/11
45	6/11
46	7/11
47	8/11
48	9/11
49	10/11

Consider the example of a worker who dies on January 1, 1986, leaving a dependent widow or widower aged 45 years and no children. The worker's average earnings are $40,000 per annum and the wife or husband is entitled to Federal benefits.

A. Federal benefits

C.P.P. pension for widow or widower = 273.35

B. Monthly permanent total disability pension rate at date of death: $75\% \times \frac{40{,}000}{12} = 2{,}500.00$

C.	60% of permanent total disability rate (Total monthly benefits under #55.31)	60% x 2,500.00 =	1,500.00	
	Maximum benefit entitlement (W.C.B. and C.P.P.) =			1,500.00
D.	Maximum monthly payment under #55.31 (C less A) =			1,226.65
E.	Minimum monthly payment set out in #55.31 =			552.28
F.	Difference between D and E (1,226.65 less 552.28) =		674.37	
G.	Plus Schedule C = 6/11ths of F (6/11 x 674.37) =			367.86
H.	Total W.C.B. benefits (E plus G) =			920.14

The minimum amount set out in #55.31 is regarded as a floor-level for pension benefits. Where the "proportion" referred to in the second column of Schedule C is a positive figure it will be added, and where it is a negative figure it will be ignored.

#55.40 Spouse Separated from Deceased Worker

Where, at the date of death, the claimant and the deceased worker were divorced, the claimant is not eligible for compensation as the deceased's widow or widower. A divorce does not, however, affect the claim of any children of the marriage.

Section 17(9) contains special provisions which apply where, though still married, the worker and dependent spouse were at the date of death living separate and apart. Section 17(9)(a) provides that, where there was in force a court-order or separation agreement providing periodic payments for support of the dependent spouse, or children living with that spouse, compensation is paid as follows:

> "(i) where the payments under the order or agreement were being substantially met by the worker, monthly payments must be made in respect of that spouse and children equal to the periodic payments due under the order or agreement; or

(ii) where the payments under the order or agreement were not being substantially met by the worker, monthly payments must be made up to the level of support that the board believes the spouse and those children would have been likely to receive from the worker if the death had not occurred."

Section 17(9)(b) provides that, where there was no court order or separation agreement in force at the date of death providing periodic payments for support of the dependent spouse, or children living with that spouse, and:

"(i) the worker and dependent spouse were living separate and apart for a period of less than 3 months preceding the date of death of the worker, compensation is payable as if they had not been separated; or

(ii) the worker and dependent spouse were separated with the intention of living separate and apart for a period of 3 months or longer preceding the death of the worker, monthly payments must be made up to the level of support which the board believes the spouse and those children would have been likely to receive from the worker if the death had not occurred."

In circumstances where the spouses were living separately for a period of three months or longer preceding the death of the worker, and there was no court order or separation agreement in force at the date of death providing periodic payments for support of the dependent spouse, or children living with that spouse, the following guidelines are provided to assist in the interpretation of Section 17(9)(b)(ii):

1. Intention to Live Separate and Apart Absent

   If it is concluded that the spouses, although living separately, did not have the “intention” of living separate and apart, Section 17(9)(b)(ii) does not apply. In these circumstances, the dependants’ entitlement would be determined under the other provisions of Section 17.

2. Intention to Live Separate and Apart Present

   If it is concluded that the spouses were living separately, with the “intention” of living separate and apart, Section 17(9)(b)(ii) is applicable. The benefits payable in these circumstances would be based on the level of support, which the Board believes the dependent

spouse and children would have been likely to receive from the worker, if the death had not occurred.

3. Determination of Intention to Live Separate and Apart

Whether the worker and dependent spouse were separated with the "intention" of living separate and apart requires an examination of all the circumstances to determine whether the geographical separation is consistent with the normal continuation of the marriage, or whether these circumstances bring into question the continued existence of the marriage. The presence or absence of this mental element concerning the status of the relationship should be assessed both on an objective and subjective basis, rather than being solely based on the subjective views of the spouses.

The question is whether, on the basis of all the evidence, the spouses either treated the marriage as being at an end or, alternatively, whether it may be concluded on an objective or "de facto" basis that the marriage had no continuing existence.

It would be sufficient to support a conclusion that the spouses were living separate and apart if one spouse (not necessarily both) treated the marriage as being at an end. Also, it could be concluded on an objective basis that the spouses were living separate and apart, notwithstanding the subjective belief of both spouses that the marriage was continuing. This might be the case if the separation was for an indefinite period and there was no reasonable prospect of their being reunited in the foreseeable future. It might be considered that they had at least reconciled themselves to this situation, notwithstanding the subjective continuance of the marriage relationship. On the other hand, if the spouses viewed themselves as continuing in their marriage and intended to reunite, and it was considered that this would occur in the reasonably foreseeable future, then it might be concluded that they were not living separate and apart.

It would not normally be considered that the spouses were living separate and apart in circumstances where a period of temporary separation was necessitated by the worker's employment.

To be eligible to claim under Section 17(9), a spouse must first be found by the Board to have been an actual dependant of the deceased as discussed in #54.00. It is not sufficient that the claimant, though not actually dependent, had a reasonable expectation of pecuniary benefit from the continuation of the life of the deceased.

In no case can the compensation payable under Section 17(9) exceed the amount that would have been payable if there had been no separation. (15)

The full amount of the lump sum provided for in #55.10 is payable to a dependent widow or widower whose entitlement is governed by Section 17(9).

EFFECTIVE DATE: January 1, 1984

APPLICATION: Applies to claims adjudicated on or after January 1, 1984.

#55.50 Recalculation of Benefits on Change of Circumstances

Where an invalid spouse ceases to be an invalid, or a widow or widower with dependent children no longer has dependent children, or there is a reduction in the number of dependent children, the spouse, widow, widower or children shall then be entitled to the same category of benefits as would have been payable if the death of the worker had occurred on the date the invalid spouse ceases to be an invalid or the widow or widower no longer has dependent children, or the number of dependent children is reduced, as the case may be. (16)

In applying this provision, it will in most cases be necessary to determine the amount of compensation which would have been payable to the deceased worker for permanent total disability. That amount is calculated by reference to the date of injury or the date of disablement from occupational disease and not by reference to the date of death (unless it is the same) or to the date of the change of circumstances. However, Consumer Price Index adjustments to the resulting figure will be made.

Where the change which leads to the recalculation is a change in a child's school attendance or a child's birthday, the Board uses the exact date when the change occurs as the date of commencement of the new benefits. For example where a child who is no longer attending school has an 18th birthday on December 15, the old pension remains in effect until December 14 and the new pension will become effective December 15.

Widows or widowers are advised at the outset of the claim of the various provisions which may result in a change in the benefits payable to them. They are also advised one year in advance of a potential change in their pension resulting from an age change in a dependent child.

#55.60 Termination of Benefits

Except as outlined in #55.61, monthly payments to a widow**,** widower**,** common law wife or common law husband continue as long as they live.

#55.61 Remarriage of Widow or Widower or Establishment of Common-Law Relationship Prior to April 17, 1985

If a remarriage of a widow or widower occurred prior to April 17, 1985 or a common law relationship was established prior to April 17, 1985, the former Section 19(1) provided that "Where a widow, widower, common law wife or common law husband of a deceased worker marries, or without marrying, lives with a man or woman in the relationship of a man and wife, the monthly payments attributable to that person as a widow, widower, common law wife or common law husband shall cease, but that person shall be entitled in lieu of them to a sum equal to the monthly payments attributable to that person as widow, widower or common law wife or common law husband for 2 years; but that person shall not receive less in total compensation than ..." the total of:

(a) the funeral and death expenses referred to in #53.00;

(b) the capital sum referred to in #53.32; and

(c) the lump sum referred to in #55.10.

To calculate the remarriage allowance, the Board took the rate of monthly payment attributable to the widow, widower or common-law wife or common law husband as at the date of remarriage, and paid 24 times that amount. The sums referred to in #53.00, #55.32 and #55.10 were the dollar amounts applicable at the date of death.

Notwithstanding the application of the former Section 19(1), payments attributable to children as dependent children continued. (17) In attributing the monthly allowances to a widow or widower or to children, the apportionment provision in #63.10 applied.

#55.62 Interest Payment Arising from the Application of Section 19(2)

Where interest is payable as a result of the application of Section 19(2) it is calculated at the rates and in the manner set out in #50.00.

#56.00 WIDOWS AND WIDOWERS DEATH PRIOR TO JULY 1, 1974

#56.10 Lump Sum Payable to Dependent Widows

In addition to any other compensation provided, a dependent widow or foster-mother in Canada to whom compensation is payable is entitled to a lump sum of five hundred dollars. (18)

#56.20 Dependent Widows and Invalid Widowers with Dependent Children

Where the dependants are a widow or an invalid widower and one or more children, a monthly payment of one hundred and seventy-five dollars and fifty-two cents is made, together with

(a) an additional monthly payment of fifty-seven dollars and fourteen cents for each child under the age of 16 years and for each invalid child of any age for whom no payment is made under paragraph (b) or (c); and

(b) an additional monthly payment of sixty-four dollars and twenty-nine cents for each child while regularly attending an academic, technical or vocational school at any time between the child's 16th and 18th birthdays; and

(c) an additional monthly payment of seventy-one dollars and forty-two cents for each child while regularly attending an academic, technical, or vocational school at any time between the child's 18th and 21st birthdays. (19)

The dollar amounts set out above apply in respect of deaths occurring on or after January 1, 1974. Different amounts applied to prior periods. "Invalid child" is defined in #59.13.

#56.30 Dependent Widows and Invalid Widowers with No Dependent Children

Where the dependant is a widow or an invalid widower without any dependent children, a monthly payment of one hundred and seventy-five dollars and fifty-two cents is made during the life of the surviving spouse. (20) Different dollar amounts applied in respect of deaths occurring prior to January 1, 1974.

#56.40 Widow or Widower Separated from Deceased

There are no special rules for widows or widowers living separate from the deceased in the case of deaths occurring prior to July 1, 1974.

Spouses who are not residing in Canada at the date of death are discussed in #62.00.

#56.50 Additional Payments

Section 18(1) of the *Act* provides that "Where, on July 1, 1974,

(a) compensation is being paid to dependants in respect of deaths occurring prior to that date;
(b) those dependants are not receiving or entitled to receive benefits under the Canada Pension Plan; and
(c) the dependant is a widow who is 50 years of age or over, or is an invalid spouse, or the dependants are children, or a widow and children,

there must be added to the monthly payments . . ." the sums set out below for each such dependent spouse and each dependent child. These dollar amounts are subject to Consumer Price Index adjustments.

		Spouse	**Child**
January 1, 2007	— December 31, 2007	$396.65	$123.11
January 1, 2008	— December 31, 2008	$406.11	$126.05

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

Where dependants would qualify for the increases set out in Section 18(1) but for the fact that they are receiving or entitled to receive benefits under the Canada Pension Plan, and where the amount of benefits under the Canada Pension Plan is less than the amounts set out in Section 18(1), the monthly payments payable to those dependants are increased by the amount by which the benefits under the Canada Pension Plan are less. (21)

The phrase "benefits under the Canada Pension Plan" in Section 18(1)(b) means benefits payable under the Canada Pension Plan and to which the dependants or any of them are entitled as a result of the death, together with any benefits to which the widow is entitled as a result of having retired or reached retirement age. But it does not include any disability benefit payable to a dependant.

#56.60 Termination of Benefits

#56.61 Remarriage

If a dependent widow or common-law wife of the deceased married before July 1, 1974, the monthly payments to her ceased, but she was entitled in lieu of them to a sum equal to the monthly payments for two years, but not to exceed

$2,500. (22) This provision did not apply to payments to a widow or common law wife in respect of a child. (23)

For remarriages on or after July 1, 1974, the $2,500 limitation did not apply. (24)

The provisions in #56.61 are superseded by the application of the current Section 19 where the remarriage occurred on or after April 17, 1985 .

#56.63 Cessation of Childrens Benefits

Except as otherwise provided, payments in respect of a child under the age of 16 years shall cease when the child attains the age of 16 years or dies, provided that in case the child at the time of attaining the age of 16 years is an invalid the payments shall continue until the child ceases to be an invalid. Payments in respect of an invalid child over the age of 16 years shall cease when the child ceases to be an invalid or dies. (25)

#56.64 Widower Ceases to be Invalid

Where compensation is payable to an invalid widower, if the widower ceases to be an invalid widower, the Board may cease paying compensation to him. (26)

#56.65 Readjustment of Payments

Where a payment to any one of a number of dependants ceases, the Board may in its discretion readjust the payments to the remaining dependants so that the remaining dependants are thereafter entitled to receive the same compensation as though they had been the only dependants at the time of the death of the worker. (27)

#57.00 COMMON-LAW WIVES OR COMMON-LAW HUSBANDS

The phrase “common-law wife” or “common-law husband” is used in regard to situations in which two people of opposite sex are living together in a regular and established way, enjoying sexual relations and a common household. There is no question of the relationship being a legally valid marriage, and no reason therefore why legal capacity to solemnize a valid marriage should be a qualification for this position. A woman or a man is not excluded from being a common-law wife or common-law husband of one person simply because she or he is legally married to another.

#57.10 No Surviving Dependent Widow or Widower

Where a worker has lived with and contributed to the support and maintenance of a common-law wife or common-law husband, and:

(a) where the worker and the common-law wife or common-law husband have no children, for a period of three years; or

(b) where the worker and the common-law wife or common-law husband have children, for a period of one year

immediately preceding the worker's death, and where the worker does not leave a dependent widow or widower, the Board may pay the compensation to which a dependent widow or widower would have been entitled to the common-law wife or common-law husband. (28)

The phrase "have children" in paragraph (b) means that the children must be born of the relationship between the worker and the common-law wife or common-law husband. The fact that children have been brought into the relationship from a previous relationship is not sufficient. On the other hand, such children may have claims in their own right as children of the deceased, even if brought into the relationship by the common-law wife or common-law husband. (29)

For example, a person living with a worker at the time of death, but being maintained by her or his legal spouse, would be denied compensation. This would not be because the person is excluded from the definition of "common-law wife" or "common-law husband", but because the person was not being maintained by the deceased worker.

#57.20 Surviving Dependent Widow or Widower

Where

(a) a worker has lived with and contributed to the support and maintenance of a common-law wife or common-law husband for the period set out in #57.10;

(b) the worker also left surviving a dependent widow or widower from whom, at the date of death, the worker was living separate and apart; and

(c) there is a difference in the amount of compensation payable to the widow or widower by reason of the separation and the amount of compensation that would have been payable to that person, if that person and the worker had not been living separate and apart,

the Board may pay compensation to the common-law wife or common-law husband up to the amount of the difference. (30)

The common-law wife's or common-law husband's pension, once set, remains fixed and does not fluctuate in accordance with changes in the surviving widow's or widower's pension. An example of this would be when any child of the deceased, living with the widow or widower, reaches the age of 18 years and ceases to attend school.

#57.30 Lump Sum Payment

Common-law wives or common-law husbands in Canada to whom compensation is payable in respect of a death occurring on or after July 1, 1974 are entitled to the lump sum payment referred to in #55.10.

#57.40 Termination of Benefits

Where the common-law wife or common-law husband of a deceased worker remarries, the policy set out in #55.60 and #55.61 applies.

#57.50 Death Prior to July 1, 1974

In the case of deaths prior to July 1, 1974, no compensation is paid to the common-law wife if there is a surviving dependent widow. Compensation is payable where there is no such widow but the qualifying periods, during which the deceased must have contributed to the support and maintenance of the common-law wife, are six years where there are no children and two years in any other case. (31)

#58.00 FOSTER PARENTS

Where the worker leaves no dependent widow or widower, or the widow or widower subsequently dies, and the Board considers it desirable to continue the existing household, and when a suitable person acts as a foster parent in keeping up the household and taking care of and maintaining the children entitled to compensation, in a manner satisfactory to the Board, the same allowance shall be payable to the foster parent and children as would have been payable to a widow or widower and children, and shall continue as long as the conditions continue. (32)

A foster parent means a person who assumes responsibility for the care and maintenance of a dependent child or children. For the purposes of Section 17(3)(j) of the Act, a foster parent may include a natural parent who did not have physical custody of the child or children at the time of the workplace fatality.

The allowance includes the lump sum payable to widows or widowers referred to in #55.10.

Similar rules apply in regard to deaths occurring prior to July 1, 1974, although the wording of the Act is slightly different. (33)

#59.00 CHILDREN

Children who were not dependent on the earnings of the deceased in the manner set out in #54.00 are not entitled under the provisions set out below. They may, however, be entitled under the provisions set out in #61.00.

#59.10 Meaning of "Child" or "Children"

By virtue of Section 1, a “child” means a son, daughter, grandson, granddaughter, stepson, stepdaughter, brother, sister, half-brother, or half-sister of the deceased worker. It also means a child otherwise unrelated to the worker to whom the worker stood in “loco parentis”.

To be eligible, a child within one of the above categories must also satisfy one of the three following requirements. The child must be

(a) a child under the age of 18 years, including a child of the deceased worker yet unborn;

(b) an invalid child of any age; or

(c) a child under the age of 21 years who is regularly attending an academic, technical or vocational place of education. (34)

#59.11 In Loco Parentis

It is not possible to specify in advance when a deceased worker will be considered to have been in “loco parentis” to a child. The decision will, in each case, depend on the particular circumstances of the claim. Generally, the evidence will have to show that the deceased acted as, and assumed the responsibility of, a parent of the child. Normally, the deceased worker will have been living with and maintaining the child, but it may be possible to establish an in “loco parentis” relationship even where they were not living in the same household.

The evidence must show that the in “loco parentis” relationship continued to exist right up to the date of death. It is not sufficient simply to establish that such a relationship existed at some past time. There is no presumption under the *Workers Compensation Act* that, once an in “loco parentis” situation is found to have existed, it must be deemed to have continued to exist unless and until there is evidence to the contrary.

#59.12 Unborn Children

Benefits payable in respect of an unborn child of a deceased worker commence from the date of death of the worker, and not from the date of the child's birth. If the child is stillborn, the provision set out in #55.50 applies as from the date of birth.

Under the Canada Pension Plan a widow who is pregnant at the date of the worker's death receives a pension for the child from the first day of the month in which it is born. The amount of workers' compensation benefits will be adjusted when the child is born according to the Canada Pension Plan benefits then being received.

#59.13 Invalid Children

"Invalid child" includes a ". . . child who, though not an invalid at the date of death of the worker, becomes an invalid before otherwise ceasing to be entitled to compensation." "Invalid" means ". . . physically or mentally incapable of earning." (35)

#59.14 Regularly Attending an Academic, Technical or Vocational Place of Education

This item refers to a child over the age of 18 and under the age of 21.

There is no requirement that the attendance at the place of education must be full time or at a certain time of day. Students who attend school during the daytime are free to work at night, so that there can be no objection to a child working in the daytime and attending school at night. However, this is subject to the nature of the course being taken. If, for example, all that is being done by the child is attending a single course, one night per week, which may lead to a degree in 10 years or so, it might be difficult to conclude that he or she was "regularly attending" a place of education.

Correspondence courses taken at home are not sufficient. The only possible exception might be where the period of home study is temporary and the child intends to return shortly to a place of education.

Apprenticeships do not qualify since they involve practical work in a work place as opposed to attending a place of education.

Prior to July 25, 1977, the Board's practice was to suspend the portion of a pension over the summer months which was attributable to a child over 18 until it was confirmed that the child did actually return to school. Following that date, the procedure is that, when a child reaches age 18, the widow or widower and/or

the child will be contacted with regard to plans for continuing education. If the child plans to continue his or her education, the child will be advised that pension benefits will be paid until age 21, including summer months, as long as the child pursues his or her education. In the absence of fraud or misrepresentation, no overpayment will be declared if the child, in fact, does not return to school.

Temporary absences from school will not cause a discontinuation of benefits as long as the Board is satisfied that there is a clear intention to eventually return to the educational program.

#59.20 Amount of Compensation

#59.21 Surviving Widow, Widower, Common-Law Wife or Common-Law Husband

Where there is a surviving spouse or common-law wife or common-law husband eligible for periodic benefits, the children's benefits are calculated in conjunction with those of the spouse or common-law wife or common-law husband under #55.00 and #57.00. This is so whether the children live with the spouse or common-law wife or common-law husband or not. Where they live apart, the apportionment provisions described in #63.10 may be applied to the pension.

Where the surviving spouse or common-law wife or common-law husband are eligible to receive a lump sum benefit, and there are also dependent children who live apart, the lump sum will be paid as described in #55.32 and the children's benefits will be paid periodically and will be calculated as per #59.22.

Even if there is no surviving spouse or common-law wife or common-law husband eligible for benefits, a pension calculated under #55.00 may by payable to a foster-parent under the provision described in #58.00.

Where there is a widow or widower and a child or children, and the widow or widower subsequently dies, the allowances to the children shall, if the children are in other respects eligible, continue and shall be calculated in like manner as if the worker had died leaving no dependent spouse. (36) The rules described in #59.22 will apply to determine the children's entitlement.

#59.22 No Surviving Spouse or Common-Law Wife/Husband

Where there is no surviving spouse or common-law wife or common-law husband eligible for monthly payments under this section, and

(a) the dependant is a child, a monthly payment is made of a sum that, when combined with Federal benefits to or for that child, would equal 40% of the monthly rate of compensation under this Part that would

have been payable if the deceased worker had, at the date of death, sustained a permanent total disability;

(b) the dependants are two children, a monthly payment is made of a sum that, when combined with Federal benefits payable to or for those children, would equal 50% of the monthly rate of compensation under this Part that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability; or

(c) the dependants are three or more children, a monthly payment is made of a sum that, when combined with Federal benefits payable to or for those children, would equal the total of

(i) 60% of the monthly rate of compensation under this Part that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability; and

(ii) the amount set out in #55.21 per month for each child beyond three in number. (37)

The computation formula is similar to the one used for computing widows' or widowers' pensions described in #55.21-#55.22. Only the percentages taken of the projected permanent total disability pension are different. "Federal benefits" has the meaning set out in #55.24 and the minimum average earnings referred to in #55.26 is applicable.

#59.30 Death Prior to July 1, 1974

Where there was a surviving widow or invalid widower, one pension was paid for that person and the children in accordance with the rules set out in #56.20.

Where the dependants are children, there being no dependent widow or dependent invalid widower

(a) a monthly payment of sixty-four dollars and twenty-nine cents is made to each child under the age of sixteen years and to each invalid child of any age for whom no payment is made under paragraph (b); and

(b) a monthly payment of seventy-eight dollars and fifty-six cents is made to each child while regularly attending an academic, technical, or vocational school between the child's 16th and 21st birthdays. (38)

The above dollar amounts apply to deaths occurring on or after January 1, 1974. Different amounts apply in respect of prior periods.

The meaning of "invalid child" is as set out in #59.13. The provision set out in #56.63 dealing with the cessation of children's benefits also applies here.

#60.00 OTHER RELATIVES

Where there is no dependent spouse or child entitled to compensation, but a worker leaves other dependants, payment is made of a sum reasonable and proportionate to the pecuniary loss suffered by those dependants by reason of the death, to be determined by the Board, but not exceeding in the whole the maximum set out below per month. (39)

July 1, 2000	—	December 31, 2000	$449.12
January 1, 2001	—	June 30, 2001	457.91
July 1, 2001	—	December 31, 2001	465.10
January 1, 2002	—	June 30, 2002	466.70

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

Except in the case of parents, no compensation is payable to other relatives who were not dependants of the deceased worker in accordance with the principles set out in #54.00.

#60.10 Dependent Parents

Where there is a dependent spouse, or a dependent child or children, entitled to compensation, but not a spouse and child or children, and, in addition, the worker leaves a dependent parent or parents, then, in addition to the compensation payable to the spouse or children, payment is made of a sum, reasonable and proportionate to the pecuniary loss suffered by the dependent parent or parents by the death, to be determined by the Board, but not exceeding the maximum set out in #60.00 per month. (40)

The provision in #60.00 also applies to dependent parents.

Parents who were not dependent on the earnings of the deceased in the manner set out in #54.00 are not entitled under the above provisions. They may, however, be entitled under the provisions set out in #61.00.

#60.20 Death Prior to July 1, 1974

The rules set out in #60.00-60.10 also apply to deaths occurring prior to July 1, 1974, although the wording of the Act is slightly different. (41)

Payments in this case continue only so long as, in the opinion of the Board, it might reasonably have been expected had the worker lived he would have continued to contribute to the support of the dependants. (42)

#61.00 PERSONS NOT DEPENDENT ON THE EARNINGS OF THE DECEASED

Where

(a) no compensation is payable to a dependant of the deceased, or

(b) the compensation is payable only to a spouse, a child or children, or a parent or parents,

but the worker leaves a spouse, child, or parent who, though not dependent upon the worker's earnings at the time of death, had a reasonable expectation of pecuniary benefit from the continuation of the life of the worker, payments, at the discretion of the Board, are made to that spouse, child or children, parent or parents, but not to more than one of those categories, not exceeding the maximum set out in #60.00 per month for life or a lesser period determined by the Board. (43)

An application for compensation from a spouse, child, parent, or other person on the grounds that he or she is a dependant of the deceased worker will automatically be considered under the above provision if it is concluded that the person was not a dependant.

In the case of deaths prior to July 1, 1974, total payments under this provision cannot exceed in the aggregate one thousand five hundred dollars. (44) This limit does not apply where it is exceeded because of Consumer Price Index adjustments.

#62.00 NON-RESIDENT DEPENDANTS

In the case of a death occurring prior to July 1, 1974, where the dependants are residing outside of Canada and entitled to compensation, the Board may award the dependants such lesser sum as in the opinion of the Board would at the date of death maintain them in a like degree of comfort as dependants of the same class residing in Canada. Should such a dependant subsequently become resident in Canada, the Board may revise the award so as to provide the same amount as provided for a dependant resident in Canada at the time of the death of the worker and to continue it for the period of such residence. (45)

Where the non-resident dependant is a child at school, payments are adjusted on the child's 16th and 18th birthdays.

No such provisions apply to deaths occurring on or after July 1, 1974. However, the provisions discussed in #55.40 can apply.

#62.10 Return of Dependant from Abroad

Where a dependant resident abroad at the time of death subsequently becomes resident in Canada, the Board will decide according to the circumstances of the individual case whether the allowance will be raised. For example, where it appears that the move to Canada was caused in some way by the death, the Board will be more likely to raise the rate than in a case where the move to Canada occurred some years later, was purely coincidental, and in no way resulted from the death.

#62.20 Consumer Price Index

Prior to July 1, 1974, the practice of the Board was that adjustments pursuant to the Consumer Price Index of Canada were not applied to the benefits of dependants resident abroad, but the rates payable to such residents were reviewed annually to "maintain them in a like degree of comfort, etc." This practice has been discontinued. Commencing on July 1, 1974, Consumer Price Index adjustments are applied to benefits of non-resident dependants in the normal way. (46)

#63.00 MISCELLANEOUS PROVISIONS

#63.10 Apportionment

Where in any situation there is a need to apportion allowances payable to dependants among those dependants, the formula for apportionment shall be at the discretion of the Board; but, unless the Board has grounds for a different apportionment, the apportionment shall be

(a) where there is a dependent spouse and one child, two-thirds to the dependent spouse and one-third to the child;

(b) where there is a dependent spouse and more than one child, one-half to the dependent spouse and one-half among the children in equal shares; and

(c) where there are children but no dependent spouse, among the children in equal shares. (47)

In a claim considered by the Board, a worker was fatally injured in circumstances that made the death compensable under the Act. He had been married twice

and survived by a widow, by a child of the first marriage, and by a child of the second marriage. Both children were dependent children of the deceased worker. The child of the first marriage was living with her mother, and at the time of the death, was being supported by the deceased worker at the rate of $75.00 per month. The Board had to determine the apportionment of the benefits payable under #55.21 as between the widow and the child of the second marriage on the one hand, and the child of the first marriage on the other hand.

The application of the formula set out in Section 17(14) would have resulted in periodical payments to the child of the first marriage considerably in excess of the level of support being provided by the deceased worker. An alternative formula was to pay on behalf of the child of the first marriage the difference between the total workers' compensation benefits that would be payable in respect of a widow and two children and the total workers' compensation benefits that would be payable in respect of a widow and one child. Applying that formula in this case, it would work out at $76.17 per month in respect of the child of the first marriage. These circumstances were grounds for a different apportionment from that which would otherwise be applicable under Section 17(14). The alternative formula was applied.

Section 17(14) is applicable to deaths occurring on or after July 1, 1974.

#63.20 Enemy Warlike Action

Where personal injury to, disablement of, or death of a worker occurs in the course of employment as a direct result of enemy warlike action or counteraction taken against it and provision has been made for compensation in respect of it for the worker or the worker's dependants by the Government of Canada, the worker or the dependants are entitled to compensation only when the compensation provided by the Government of Canada is less than that provided by this Act, and then only to the extent of the difference. (48)

#63.30 Death of Two Workers

A dependant who, when receiving or entitled to receive compensation as the result of the death of a worker, becomes entitled to receive compensation as the result of the death of another worker, will receive in the whole the compensation that the Board may, in its discretion, determine; but in no case will the compensation be less than the higher of the amounts payable in respect of the death of either worker, or more than 75% of the maximum amount of average earnings. (49)

#63.40 Special or Novel Cases

Section 17(17) provides that where a situation arises that is not expressly covered by the provisions discussed in this chapter or where some special additional facts are present that would, in the Board's opinion, make the strict application of those provisions inappropriate, the Board can make rules and give decisions it considers fair, using those provisions as a guideline.

This provision is applicable to deaths occurring on or after July 1, 1974.

#63.50 Proof of Existence of Dependants

The application for compensation submitted by a dependant should be accompanied by marriage and/or birth certificates or other evidence establishing the applicant's relationship to the deceased.

Section 20 provides that "The board may from time to time require the proof of the existence and condition of dependants in receipt of compensation payments that is deemed necessary by the board, and pending the receipt of that proof may withhold further payments."

Each year, the Board mails out, to dependants receiving pensions, declaration forms and school attendance forms. Failure to complete and return these forms may result in the suspension of payments.

#63.60 Commencement of Pensions

Pensions awarded to a dependent or non-dependent relative of a deceased worker commence on the day following the date of death.

#63.70 Death of Commercial Fisher After January 1, 1975

Section 4(3) of the Act provides that "Where the death of a commercial fisherman resident in British Columbia arises out of and in the course of his occupation in the Province or waters off the Province after January 1, 1975, and the death is not otherwise compensable . . ., the board may treat the death in the same manner as if the commercial fisherman were a worker employed by the Crown in right of the Province."

NOTES

(1) S.5(1); See Chapter 3
(2) S.6(1); See Chapter 4
(3) S.17(2)
(4) S.1
(5) S.17(13)
(6) See #37.00
(7) S.17(3)(a)
(8) S.17(3)(b)
(9) S.17(1)
(10) S.17(3)(g)
(11) S.17(3)(c)
(12) S.17(3)(c), prior to amendment by S.2, *Workers Compensation Amendment Act*, 1975
(13) S.17(3)(d)
(14) S.17(3)(e)
(15) S.17(10)
(16) S.17(4)
(17) S.19(2)
(18) S.17(2)(i), prior to repeal by S.14, *Workmen's Compensation Amendment Act*, 1974 (hereafter referred to as W.C.A., 1974)
(19) S.17(2)(b), prior to repeal by S.14, W.C.A., 1974
(20) S.17(2)(a), prior to repeal by S.14, W.C.A., 1974
(21) S.18(2)
(22) S.20(1), prior to repeal by S.16, W.C.A., 1974
(23) S.20(2), prior to repeal by S.16, W.C.A., 1974
(24) S.19(4)
(25) S.17(5), prior to repeal by S.14, W.C.A., 1974
(26) S.17(2)(j), prior to repeal by S.14, W.C.A., 1974
(27) S.17(6), prior to repeal by S.14, W.C.A., 1974
(28) S.17(11)
(29) See #59.11
(30) S.17(12)
(31) S.17(2)(h), prior to repeal by S.14, W.C.A., 1974
(32) S.17(3)(j)
(33) S.17(2)(g), prior to repeal by S.14, W.C.A., 1974
(34) S.17(1)
(35) S.1
(36) S.17(5)
(37) S.17(3)(f)
(38) S.17(2)(c), prior to repeal by S.14, W.C.A., 1974
(39) S.17(3)(h)(i)
(40) S.17(3)(h)(ii)
(41) S.17(2)(d)(i)-(ii), prior to repeal by S.14, W.C.A., 1974

(42) S.17(4), prior to repeal by S.14, W.C.A., 1974
(43) S.17(3)(i)
(44) S.17(2)(e), prior to repeal by S.14, W.C.A., 1974
(45) S.17(2)(f), prior to repeal by S.14, W.C.A., 1974
(46) See #51.12
(47) S.17(14)
(48) S.17(15)
(49) S.17(16)

CHAPTER 9

AVERAGE EARNINGS

#64.00 INTRODUCTION

Whether payable to disabled workers or dependants of deceased workers, compensation is normally based on the worker's "average earnings". Occasionally it is based wholly or partly on fixed amounts set out in the Act which are subject to Consumer Price Index adjustments.

#65.00 AVERAGE EARNINGS

Section 33(1) of the Act provides in part as follows:

> "The average earnings and earning capacity of a worker must be determined with reference to the average earnings and earning capacity at the time of the injury, and may be calculated on the daily, weekly or monthly wages or other regular remuneration which the worker was receiving at the time of the injury, or on the average yearly earnings of the worker for one or more years prior to the injury, or on the probable yearly earning capacity of the worker at the time of the injury, as may appear to the board best to represent the actual loss of earnings suffered by the worker by reason of the injury, but not so as in any case to exceed the maximum wage rate, . . ."

This section provides for various alternative methods of calculating average earnings. It obliges the Board to select for each claim the method which most accurately represents the workers actual loss of earnings by reason of the injury. This does not mean that Claims Adjudicators have complete freedom of choice in respect of each individual claim. In addition to considering the circumstances of each individual claim, the Board must ensure that the application of Section 33 is consistent between different claims. This requires that the Board lay down a framework of principles which Claims Adjudicators are required to follow. However, within that framework, the Claims Adjudicator retains the basic discretion granted by Section 33(1) to calculate a particular worker's average earnings in accordance with the method that most accurately reflects the loss.

There will be situations where the framework laid down by the Board, when applied to an individual case, will not meet the principles of, or the intent of, Section 33(1). Therefore the discretion allowed under Section 33(1) of the Act may require that the Adjudicator exercise judgment in calculating average earnings that would ". . . appear to the board best to represent the actual loss of earnings suffered by the worker by reason of the injury, but not so as in any case

to exceed the maximum wage rate, . . ." The Adjudicator will not, however, interpret "best" to mean the highest rate possible, but rather to select the rate which most closely reflects the actual loss incurred.

The general provisions of Section 33(1) are modified in respect of particular situations by other provisions of the Act.

Set out below is the framework of principles adopted by the Board in its application of Section 33(1), together with other relevant statutory provisions.

#66.00 WAGE-LOSS RATES ON NEW CLAIMS

Except in the cases set out in #66.10-34, wage-loss payments made at the outset of a claim are based on the worker's rate of pay at the date of injury up to the maximum wage rate permitted by the Act. (1) Compensation based on this rate will normally continue until the end of the worker's temporary disability or the 8-week rate review, (2) whichever comes first.

Irrespective of how wages are paid by the employer, they are converted by the Board to a weekly equivalent. After conversion to a weekly equivalent, a daily wage rate is calculated by dividing the weekly earnings rate by the number of days worked in the week. The daily compensation rate is 75% of this figure.

#66.01 Variable Shift Workers

1. Short-Term Disabilities – Within One Shift Cycle

   In general, in those cases where a worker's disability does not extend beyond one short cycle of shifts (usually with a maximum disability period of two weeks or a first and final payment), the wage-loss payment is calculated by entering the worker's actual loss into the Board's computerized automated wage-loss system which calculates 75% of the loss incurred. The application of the statutory maximum entitlement is determined by the computer by reference to the amounts paid over each calendar week.

2. Disabilities Extending Beyond One Shift Cycle

   (a) Variable But Repeating Shifts

   In those cases where variable but repeating shifts are worked, for example, a nine-day fortnight shift pattern, and the Adjudicator or Claims Officer anticipates the period of disability will not be short-term, rather than pay on the basis of the actual loss as described in 1. above, the automated wage-loss system will calculate the

worker's payments. The calculations are based on the shift cycle starting date, the shift cycle pattern, and the worker's rate of pay at the time of injury (hourly rates are converted to daily or weekly amounts). An 8-week rate review, as described in #67.20, is carried out on these claims. Exceptions to this approach are made when the worker:

– works a shift cycle involving more than five cycles;

– works differing shift hours per cycle;

– is paid shift differentials;

– is scheduled for a shift cycle change.

(b) Irregular Shifts

In those cases where the worker has irregular shifts, shifts with no repeating patterns, or situations involving the four exceptions listed above, the wage rate is set using the rate setting guidelines for long-term earnings as described in #66.10, and the worker is paid on the basis of a seven-day week for the full period of temporary disability. No 8-week rate review is carried out in those cases.

#66.02 Claimant with Two Jobs

If a worker holds two jobs and is disabled from both by an injury arising out of and in the course of one of them, wage-loss compensation will be based on the combined earnings of both jobs up to the statutory maximum. This applies whether or not the other job is covered by Part 1 of the Act or is self-employment. The total days worked in both jobs are merged to obtain the days worked per week. Both employers, if covered by Part 1 of the Act, may be reimbursed by the Board if they continue paying the disabled worker. (3)

When a worker is injured on a job for which personal optional protection has been purchased and we are combining actual income earned in a second job, with the actual income earned in the job for which personal optional protection coverage has been purchased, the compensation rate on the claim cannot be less than the personal optional protection rate purchased. (See #66.20 also.)

#66.10 Use of Long-Term Earnings

Because of the irregular or varying nature of a worker's earnings, it may not be reasonable or practical to determine the rate of pay at the date of injury without

having regard to earnings over a long period of time. For example, this may apply to shift or piece workers, or cases where a significant portion of a claimant's earnings consist of commission, tips, bonuses, or intermittent overtime.

Alternatively, information available at the outset of a claim may indicate that a worker's earnings over a longer period prior to the injury are significantly greater or less than the earnings at the time of the injury. The Claims Adjudicator should investigate the claimant's earnings over the longer period (usually the one-year period prior to the injury), and determine the reasons for the difference. If satisfied that the worker's earnings over the longer period better represent the loss of earnings by reason of the injury, the Claims Adjudicator may base wage-loss payments on these earnings from the outset of the claim. Suppose, for example, there are high earnings over the previous year, but for reasons beyond the worker's control there are low earnings at the time of injury. It may be reasonable in such a case to use the worker's earnings over the year prior to the injury rather than his earnings at the time of injury. On the other hand, if the worker's earnings are lower over the longer period because of a personal choice for more leisure time over that period, it might be reasonable to use the lower earnings over the longer period.

The Adjudicator must use the figure which best represents the worker's actual loss of earnings by reason of the injury. This will not necessarily be the figure which gives the worker the highest compensation rate. Furthermore, the requirement that average earnings "at the time of the injury" be used means that payments cannot be based on earnings in a period of time in the past which terminated prior to the injury. Only earnings in a continuous period which ends with the injury can be used. For the majority of short-term disability claims, unless the difference between the rate at the time of the injury and the long-term earnings is excessive, the best representation of the short-term loss will be the rate being earned at the time of the injury.
Where it is clear that a worker is permanently totally disabled, wage-loss payments will from the outset of the claim be based on the same wage rate as the pension. (4)

#66.11 *Computation of Long-Term Earnings*

If not supplied by the employer, earnings information for the required period of time prior to the injury must be provided by the worker. Thus, information must generally be confirmed by the employer or the Income Tax Authorities. For this purpose the Board accepts wage stubs, T-4's, or letters from the Income Tax Authorities or employers or any other confirmatory evidence.

The Board policy in all cases where a person derives their income from self-employment and other employment, is not to take the net taxable income as the sole criteria for determining average earnings. The net taxable income should be looked at in light of all other relevant facts and particulars, and judgment must be given on what is reasonable in view of all the facts and circumstances. For example, regard must be had to the fact that the *Income Tax Act* may allow deductions to be made from earnings of amounts which are not relevant to a calculation of earnings for the purpose of the *Workers Compensation Act* and which distort the claimant's real earnings position.

Generally speaking, the Board does deduct from the total period over which earnings are being averaged any periods during which the claimant was receiving wage-loss compensation or for which there is medical evidence of disability. It would normally be unfair that a claimant's average earnings should be reduced because of a work injury or other illness. For example, suppose a worker had a 20-day absence due to sickness and an income of $37,000 in the year before the injury. The calculation of average earnings over the year would be as follows:

Deduct period of absence from days in year	365 – 20 = 345
Average weekly earnings	$\frac{37{,}000}{345}$ x 7 = 750.72

However, this rule does not apply in a case where a claimant is frequently absent from work through illnesses or other non-compensable disabilities. There is a substantial difference between absences due to an occasional illness which reduces a claimant's average earnings below their normal level and a normal work pattern which includes regular absences from work. In the latter case, the claimant's average earnings are most fairly calculated by not making any adjustment for the periods of absence. The procedure would also not apply in situations where a disabled worker, covered under compensation had been maintained on full salary by the employer during the period of disability. This is because the period of disability would not be reflected by a drop in income.

The above principles also apply to absences from work resulting from the taking of educational or training programs. Although periods of unemployment due to a strike are not taken into account in assessing average earnings, employees who are locked out and are not themselves involved in the labour dispute, will be given a credit for the period involved when assessing average earnings.

#*66.12 Provisional Rate*

Compensation may be based on a provisional rate if there is a delay in obtaining information required to make a decision about a worker's average net earnings. The worker must be informed that a provisional rate has been set.

The amount of the provisional rate depends on the information available to the Board officer. While being careful not to set a rate which is higher than the

worker's actual earnings, the Board officer should, as far as is possible, take into consideration the actual circumstances of the worker, for instance, age, occupation, seniority and union status. The Board officer should also have regard to statements of earnings already on file or on other recent compensation claims.

Where a Board officer sets a provisional rate, this is a preliminary determination pending receipt of further information required to determine a worker's average net earnings. If sufficient earnings information is received after payments have been made based on a provisional rate, a decision on the worker's average net earnings will then be made.

Section 96(5) of the *Act* provides that the Board may not reconsider a decision on the worker's average net earnings if more than 75 days have passed since the decision was made. The Board may also not reconsider a decision on the worker's average net earnings if a request for review has been made to the Review Division as provided for by section 96.2 of the *Act*.

A preliminary determination to set a provisional rate is not a "decision" for the purposes of section 96(5). Rather, it is a Board action that is intended to provide temporary financial relief to the worker until the Board receives the required information to make a decision on the worker's average net earnings. However, once the Board makes the average net earnings decision, that decision is subject to the provisions of section 96(5).

If insufficient earnings information or no information is received after a reasonable time, the Board officer will review the rate at least every four weeks from the date of the preliminary determination until the decision on average net earnings is made. In setting a provisional rate, regard will be had to the applicable statutory minimum. Where payments based on a provisional rate have been commenced, and the average net earnings decision sets a rate lower than the provisional rate previously set, no recovery of the payments will be made in the absence of an administrative error, fraud or misrepresentation by the worker. For a definition of an administrative error, refer to policy item #48.41.

EFFECTIVE DATE: March 3, 2003
APPLICATION: To provisional rates set on or after the effective date.

#66.13 *Casual Workers*

The rate of pay of a casual worker at the date of injury is not normally the best representation of the actual loss of earnings. Because of the sporadic employment history of such workers, the Board considers that there is a need to look at the worker's earnings over a longer period of time. It has been the Board's practice to use the casual worker's earnings for the one-year period prior to the injury, but a shorter or longer time could be used if this best represented loss of earnings.

Stevedores are treated as casual workers. Normally they are paid on a seven-day week basis. However, the actual days worked per week may be used if there is a steady work pattern.

Fishers are treated as workers engaged in casual employment. However, this rule cannot be rigidly applied without regard to the particular circumstances of the case. For instance, it is conceivable that a particular fisher could be employed 52 weeks a year, five days a week. The fisher would then have to be treated as a regular full-time worker rather than a casual worker. Similarly, it is possible that some types of fishers might be regarded as seasonal workers. Where a job is to last more than three months, the worker is generally regarded as a seasonal or full-time worker rather than a casual worker. Regulation 3 of the Fishing Industry Regulations addresses the calculation of earnings for compensation benefits.

In determining the average earnings of a fisher who owns a fishing vessel, the depreciation for income tax purposes, i.e. "capital cost allowance", is deducted from the gross income as it is not considered to be earnings. See #71.41 for the formula used in calculating the capital cost allowance or depreciation figure. Interest accrued (whether or not paid) as the result of an indebtedness, in respect of a fishing vessel used and owned by a commercial fisher, is considered an operating cost. The accrued interest is deducted from the gross income. The purchase of food as an operating cost is not deducted from the gross income as it is considered a direct benefit to the fisher and is a measurable return from the activities of fishing. The purchase of fuel, fishing nets, etc., plus costs incurred in the maintenance of the vessel and its equipment are deducted from the gross income as operating costs.

Workers in the fishing industry who are not classified as commercial fishers, such as packing house workers, will usually be considered in the same fashion as other workers in the province unless the nature of their employment is clearly seasonal. Geoduck divers are treated as commercial fishers.

Tradespersons dispatched to construction jobs from a union hiring hall, for example, carpenters, pipefitters, etc., are not for that reason alone considered as casual workers. The same applies to truck drivers or other unionized workers who, though they generally are employed full time, have prior to the injury, experienced short temporary lay-offs due to general economic conditions.

#*66.14 Seasonal Workers*

Workers injured while engaged in a seasonal occupation are normally paid wage loss on the basis of their rate of pay at the date of injury. However, if the seasonal occupation is of very short duration (normally less than three months), and the claimant has other jobs during the year prior to the injury, she or he may be treated as a casual worker.

Wage-loss payments based on the rate of pay in the seasonal job continue until the claimant’s temporary disability ceases, the 8-week rate review is undertaken

or the date when the seasonal job would have terminated, whichever comes first. If the claimant remains disabled at the time when the job would have terminated, and an 8-week rate review has not yet been carried out, it will be undertaken at this time.

The occupation of tree planting is a seasonal one.

#66.15 Part-Time and Temporary Workers

The terms “part-time” and “temporary” workers mean different things to different people. Irrespective of the terminology used to describe a job, the Board must decide whether the claimant is really a full-time worker covered by A66.00-66.10, a casual worker covered by #66.13 or a seasonal worker covered by #66.14.

Consider the following examples:

1. A person working regularly five days a week but not yet on the permanent staff is considered a full-time worker.
2. A person who works only on Saturdays is a full-time worker, but would have to lose time on the Saturday following the day of injury to be eligible for wage-loss payments.
3. A person works “on call” for one or more employers is treated as a casual worker.

Where a work week is temporarily reduced and Employment Insurance benefits are being paid to offset this partial reduction, the rate set for such a worker would be the long-term earnings figure for the year prior to the injury. When the actual earnings during the reduced week are however greater than the annual earnings, the weekly figure will be used initially and the 8-week rate change will, if it occurs, be considered in the normal fashion.

A student injured during summer employment is initially compensated on the basis of earnings at the time of the injury. Payments at this rate continue until the claimant’s temporary disability ceases, the 8-week rate review is undertaken, or the claimant returns to school. If the claimant remains disabled at the time of return to school, and an 8-week rate review has not been carried out, it will be undertaken at that time and payments continued at the new rate until the disability ceases.

#66.20 Personal Optional Protection

The “average earnings” of a person entitled to personal optional protection under Section 2(2) of the Act (6) are the earnings for which coverage has been purchased. There is no 8-week rate review.

The maximum and minimum amount of earnings for which coverage can be purchased are set out below.

	Monthly Amount		
	Maximum	**Minimum**	**With Proof of Earnings (Effective January 1/87)**
January 1, 1999 - December 31, 1999	$2,500.00	$1,000.00	$4,792.00
January 1, 2000 - December 31, 2000	2,500.00	1,000.00	4,833.00
January 1, 2001 - December 31, 2001	2,500.00	1,000.00	4,875.00
January 1, 2002 - December 31, 2002	2,500.00	1,000.00	4,967.00

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

Effective January 1, 1987, where an applicant is applying for an amount which exceeds the maximum per month, proof of earnings must be provided. If verification of earnings is not provided, the Board automatically reduces coverage to the maximum per month. Proof of earnings must be in the form of a certified copy of the applicant's previous year's tax return or a declaration must be completed by a professional accountant (C.A., C.G.A., or C.M.A.), lawyer or notary public. This declaration must certify that the self-employed earnings of the applicant for the previous year were equal to or exceeded the coverage requested.

Because of frequent changes in the maximum wage rate, where coverage at the maximum has been granted, the Board permits an application for personal optional protection at the "maximum wage rate" with coverage and assessment to be adjusted automatically from time to time.

Where a claim is made in respect of an injury, a disablement from an occupational disease, or a death from either cause occurring on or after January 1, 1978, the minimum amounts of compensation provided for in Sections 22(2), 23(4), 29(2) and 30(2) have no application to persons who have purchased personal optional protection. (7) Compensation payments to such persons shall be based on a rate of 75% of the amount of earnings for which coverage has been purchased. However, the minimum average earnings provided for in Section 17(3)(g) does apply. (8)

Where personal optional protection has been obtained for members of an employer's family under 19 years of age, the wage rate set is based upon the actual earnings of the family member in the same manner as for other workers without regard to the rate of personal optional protection purchased by the employer for the employer or his or her spouse.

If a worker is injured on the job for which personal optional protection has been purchased, and also claims a loss from some other employment, the actual loss of earnings from both jobs (up to the statutory maximum) is used for computing average earnings. The same rule applies if a worker injured in the course of an employment covered by the Act also loses earnings from an occupation for which personal optional protection has been purchased. When a worker is injured on a job for which she or he has purchased personal optional protection and we are combining actual income earned in a second job, with the actual income earned in the job for which personal optional protection coverage has been purchased, the compensation rate on the claim cannot be less than the personal optional protection rate purchased.

When assessing a permanent partial disability on a projected loss of earnings basis, the actual pre-injury earnings of persons who have purchased personal optional protection are compared with the actual earnings they might obtain after the injury in jobs which they are able to do. However, the maximum loss of earnings for which an award will be made will be the earnings figure for which coverage has been purchased. (9) In determining temporary partial disability entitlement under Section 30 of the *Workers Compensation Act*, no earnings losses incurred are considered where such losses are in excess of the amount of personal optional protection purchased.

In the case of a reopening of a claim over three years from the date of injury and the claimant had personal optional protection when initially injured:

1. Where the worker has maintained personal optional protection coverage at the time of reopening, the Board will pay the claim on the basis of the current rate of optional coverage.

2. Where the worker is still employed in a capacity requiring optional protection and has no active personal optional protection coverage at the time of reopening, the Adjudicator will use the initial personal optional protection rate plus the appropriate Consumer Price Index increases.

3. Where the claimant is now employed in circumstances where there is compulsory coverage for workers, the rate on reopening will normally be the claimant's current earnings rate subject to an evaluation of the question of any impact of the original injury on these current earnings should they be lower than that ACTUALLY EARNED (not the personal optional protection rate) at the time of the injury. (10)

Compensation payable to persons entitled to personal optional protection is subject to the same Consumer Price Index adjustments as compensation payable to other persons.

#66.30 Workers with No Earnings

Persons working without pay are not generally considered as "workers" under the *Act*. However, there are some exceptional situations of this type which are covered and for which the *Act* or the Board has specified the earnings on which compensation is to be based.

#66.31 Volunteer Workers Admitted by the Board under Section 3(5)

Where a person who is deemed to be a worker under Section 3(5) of the *Act* is not regularly employed, and having regard to all the circumstances, including income, the Board may fix the worker's average earnings at not less than the amount set out below per week nor more than the maximum wage rate provided under Section 33 of the *Act*.

July 1, 2000	—	December 31, 2000	$97.65
January 1, 2001	—	June 30, 2001	99.56
July 1, 2001	—	December 31, 2001	101.12
January 1, 2002	—	June 30, 2002	101.47

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

The minimum wage set out above is subject to Consumer Price Index adjustments.

#66.32 Volunteer Firefighters and Ambulance Drivers and Attendants

The average earnings of volunteer ambulance drivers and attendants and members of fire brigades working without remuneration is deemed to be the same in amount as the average earnings in their regular employment or employments, not, however, to be less than the amount on which the employer has been assessed. (11)

In order to provide a minimum level of coverage to volunteers who have no attachment to the labour force, the employer is assessed $75.00 per month ($17.30 per week) for each person, unless the municipality concerned has arranged with the Board for, or pays the claimant, a higher amount. Compensation is based on this rate unless or until wages are confirmed as being lost at another job. In the latter case, the rate can be increased to the rate on the job, but the $17.30 cannot be combined with it. If the volunteer is unemployed, but has an attachment to the labour force in the sense that the volunteer is seeking employment, wage-loss benefits are determined on the average earnings from the last regular employment. The fact that the volunteer is collecting Employment Insurance benefits confirms for our purposes an

attachment to the labour force. In most cases, one year's earnings prior to the date the worker was last employed should be used to determine the level of benefits. If a firefighter is paid wages by the fire brigade these can be combined with earnings from another job, but not to exceed the maximum wage rate.

Volunteer firefighters who have no attachment to the labour force such as a retired person or someone in receipt of welfare payments would not generally have a loss of wages as a result of an injury. Claims for these individuals are paid on the basis of a $75.00 per month assessment figure or greater where the municipality arranges a higher valuation on the volunteer services.

There will be circumstances which do not fall squarely within these guidelines. When that occurs, the decision on what best represents the loss of earnings must be decided upon by the Claims Officer or Claims Adjudicator according to the merits and justice of the particular case.

Firefighters, other than those referred to in 20:10:30 of the *Assessment Policy Manual* or firefighters whose employers are not covered by Part 1 of the *Act*, but to whom personal optional protection has been given, are to be assessed and paid on the same basis as above.

#*66.33 Sisters in Catholic Institutions*

Claims are occasionally received for teaching or nursing sisters of Catholic institutions. If they are being paid wages they are treated as normal workers and compensated on the basis of their actual earnings. If no wages are being paid, their earnings are deemed to equal the amount on which their employers are assessed. This amount is $75.00 per month ($17.30 per week) for each person.

#*66.34 Emergency Services Workers*

Average earnings used in claims by Emergency Services Workers are the earnings in the worker's ordinary employment but where the worker has no regular employment are fixed by the Board at a figure not less than $25.00 per week nor more than the maximum under the *Act*. (12)

#67.00 WAGE-LOSS RATE CHANGES

The change from a provisional wage-loss rate to a rate based on the claimant's actual earnings was dealt with in #66.12. In addition, the rate changes referred to below may be applicable.

#67.10 Adjustments to Earnings of Learners

Section 33(3) provides that

> "Where the board is satisfied that the average earnings of the worker at the time of injury by reason of the worker's age or the worker being in the course of learning a trade, occupation, profession or calling do not truly represent the worker's average yearly earnings or earning capacity, it may, in the case of temporary disability, adjust from time to time the payments of compensation to take into account the probable increase in average earnings and may, in the case of permanent disability, calculate the award by taking into account the probable increase in average earnings."

A distinction must be drawn between learning a trade, occupation, profession or calling and working through an initial probationary period required by an employer for the purpose of determining that job performance is satisfactory. Only the former is covered by Section 33(3).

Section 33(3) does not automatically apply just because a worker is young and has low earnings. There must be evidence that the low earnings were because of the worker's youth and that, but for the injury, the earnings would have increased.

This section does not alter the general rules which determine the claimant's average earnings for the purpose of calculating initial wage-loss payments. It only provides a mechanism whereby this rate may be reviewed and increased from time to time in the future.

The question arises as to whether an 8-week rate change should be made on a claim where rates are subject to adjustment under Section 33(3) of the Act. The practise is as follows:

(a) If the apprentice was fully employed with one employer during the year prior to the injury with little or no lay-offs, it is considered that the ongoing adjustments under Section 33(3) are a better representation of the ongoing loss. As such, no 8-week rate change will be implemented in these situations. An exception to this could be made however where, due to circumstances such as a high frequency of overtime, the annual earnings produced a higher average than the incremental figures under Section 33(3).

(b) If, in the year prior to injury, the apprentice has been subject to lay-offs, or has served the apprenticeship with a number of different employers, it would be more appropriate to use the annual earnings

figure as the reflection of a future loss rather than the incremental steps under Section 33(3).

Where it is decided to use annual earnings under either (a) or (b) above, the ratio of increase that would have been applied under Section 33(3) is also applied to increase the long-term earnings figure used for an 8-week rate change.

An adjustment under Section 33(3) cannot have the effect of increasing the claimant's rate above the maximum at the time of the injury.

When a rate is periodically adjusted under the terms of Section 33(3) it will still be adjusted for Consumer Price Index increases where appropriate in addition to the Section 33(3) adjustment, but not so as to produce a figure in excess of the current maximum.

#67.20 8-Week Rate Review

An 8-week rate review is made where wage-loss payments based on the worker's rate of pay at the date of injury have continued for eight weeks. This review consists of an enquiry and determination of what earnings rate best represents the long-term earnings loss suffered by the worker by reason of the injury.

After a claim has lasted five weeks, the Claims Adjudicator considers whether it is likely to last for eight weeks and, if the Adjudicator has not done so already, sets in motion any enquiries necessary for a possible 8-week rate review.

Where a permanent disability is anticipated, the Claims Adjudicator will consult with the Disability Awards Officer or Adjudicator in Disability Awards at the time of the 8-week rate review in order to provide consistency between the rate selection for wage-loss benefits and that set for Disability Awards purposes. The appropriate form recording the conclusion will be placed on the claim file.

Circumstances in an individual claim may require the selection of two different rates and where this occurs, the reasons are clearly recorded on the claim file. In cases of permanent total disability the wage rate must always be the same as the pension.

In situations where a worker is being maintained on full salary by the employer, the Claims Adjudicator will still be required to carry out a rate review of this kind and, if a reduction is warranted, to make the necessary adjustment. If the worker's long-term earnings average out in excess of the rate set at the time of the injury and the figure being paid by the employer, it is conceivable that the worker could be in a less advantageous position than other workers with a similar earnings pattern. As such, a rate increase can be initiated and the

difference between the new rate and what is being refunded to the employer made payable to the worker. This would not apply if the employer is paying the worker at the maximum applicable to the claim. If an employer ceases to make payments to a worker, the Board will begin to pay the worker directly.

As part of the Claims Adjudicator's enquiries, information will be obtained as to the worker's long-term earnings prior to the injury. Normally, earnings in the one-year period prior to the injury are obtained and used to reflect the worker's long-term wage loss and the pension rate. In some instances, however, the three-month figure prior to the injury may be used. Its use, however, is generally limited to those situations where there is a relatively fixed change in the worker's earning pattern which is deemed likely to continue into the future. In some instances, the Claims Adjudicator may decide to select the three-year earnings figure prior to the injury. These situations are normally limited to cases where there are extenuating circumstances in the one-year period prior to the injury and therefore the use of that one-year period would be incompatible with the worker's normal historical earnings pattern. This is sometimes occasioned by economic downturns which produce anomalies or irregularities in the earnings pattern of the worker in the year prior to the injury to the extent that they differ from the normal work history. In some exceptional circumstances, the Claims Adjudicator may decide to use the earnings in the five-year period prior to the injury. This, however, is of very limited application and would only apply to those exceptional circumstances where even the use of the three-year period would produce an inappropriate reflection of the worker's normal employment history. An example of this type of situation would be the case of a worker who for many years had been steadily employed with one company, which because of a downturn in the economy has either gone out of business or laid off some staff. Recognizing that many such long-term employees may have difficulty re-establishing themselves on a permanent basis in the labour force, but in recognition of the expectation that such workers will attempt to reinstate their earnings status on a similar basis to that in the past, the use of the average of earnings over the five years prior to the injury is felt to be appropriate at least for pension purposes. Its use for wage-loss purposes following the 8-week rate change will, however, depend on the circumstances of the case which would examine the worker's employability potential during the period of recovery from the injury.

The rules set out in #66.11 are used to calculate these earnings.

The Claims Adjudicator will also consider the probability of the worker continuing in the injury occupation. For this purpose, the Adjudicator will contact the employer to enquire whether the worker could reasonably have been expected to continue in the job. The Adjudicator will also question the worker as to future intentions with regard to this job and examine the previous employment history. Any difference of opinion between the worker and employer must be investigated

and the Adjudicator must then decide whether the continued employment of the claimant was probable.

Having completed the necessary enquiries, the Claims Adjudicator will determine the earnings rate of the worker which best represents the long-term loss of earnings. Where this decision involves a change in the amount of compensation payable, the change will take effect at the beginning of the week following the first eight weeks payment of wage-loss benefits.

Where an 8-week rate review would result in a reduction in compensation of less than $1.00 per day, no change will be made. However, all increases will be paid.

If at the beginning of the ninth week there is insufficient information on which to complete the 8-week rate review, a provisional rate will be set until sufficient information is received. (13)

Since no refunds are made to the employer when workers covered under the *Government Employees Compensation Act* are maintained on full salary, no 8-week rate review is carried out and no payments are made to the worker. If payments made by the employer are discontinued at any time beyond eight weeks of disability and a worker is still disabled, an 8-week rate review is carried out at that time. Long-term earnings data is normally obtained where there is an indication that a permanent partial disability pension may be payable.

#67.21 Class Averages/New Entrants to Labour Force

Section 33(1) provides in part as follows:

> ". . . where, owing to the shortness of time during which the worker was in the employment of his or her employer, or in any employment, or the casual nature of his or her employment, or the terms of it, it is inequitable to compute average earnings in the manner described in this subsection, regard may be had to the average daily, weekly or monthly amount which, as shown by the records of the board, was being earned during the one or more years or other period previous to the injury by a person in the same or similar grade or class of employment."

The persons covered by this provision are those whose actual earnings record is not sufficient to allow a determination of what best represents their long-term loss of earnings. For example, it may cover recent entrants into the labour force or new immigrants. In these cases, a class average is obtained when an 8-week rate review is being considered. If the class average is equal to or greater than the worker's rate of pay at the date of injury no change is usually made in the compensation rate. If the class average is lower, the compensation may be reduced accordingly.

A class average may occasionally be used at the outset of a claim where the particular circumstances show it to be the best representation of the claimant's loss.

When considering using a class average, the Claims Adjudicator should also have regard to other information that might warrant a variation from that average. For example, the Adjudicator should consider the last grade completed in school, any special training, any plans for future education, on what date the individual arrived in the province and what prior education, skills, occupation, etc. the worker had in another province or country.

The method of computing class averages is to determine the latest census figure and adjust this according to the change in the index of B.C. Salaries since that time. An adjustment is also made with respect to the census occupation code, which has fairly broad categories. Final adjustment is then made based on earnings information collected by the Board from data submitted by employers on individual claim files using a system of coded occupations. The average earnings figure is a ratio of these two figures. A number of averages are available, one involving all workers in the class and others involving restricted categories of workers in the class. The one generally used is the average for all workers in the class.

#68.00 PERMANENT DISABILITY PENSIONS

Permanent disability pensions are normally based on the earnings rate established at the point when long-term earnings are reviewed for wage-loss purposes. This, in most cases, means the rate resulting from the 8-week rate review; however, a different rate can be used if there are valid reasons for this. (14) The formula for converting the weekly wage-loss rate to the monthly pension rate is

$$\text{Weekly Wage-Loss Rate} \times \frac{365}{84} = \text{Monthly Pension Rate}$$

If there has been no review of long-term earnings for wage-loss purposes, a review will be carried out by the Disability Awards Officer or Adjudicator in Disability Awards in the same manner as a Claims Adjudicator would carry out an 8-week rate review. A provisional rate or class average may be applied in suitable cases. (15) If no earnings data is received, the pension may be based on the statutory minimum or lower. (16)

The rule in #67.10 respecting minors and learners is applicable where a disability pension is being assessed.

#69.00 MAXIMUM AMOUNT OF AVERAGE EARNINGS

Section 33(1) provides that a worker's average earnings cannot exceed the "maximum wage rate". This means that where a worker's earnings exceed the maximum wage rate compensation for temporary or permanent total disability will equal 75% of the maximum.

The Act contains a special procedure for determining the maximum wage rate in force in any year. Section 33(7) provides that "Prior to the end of each calendar year, the board must determine the maximum wage rate to be applicable for the following calendar year." The maximum wage rate to be determined under Subsection (7) is an amount that the Board thinks represents the same relationship to the sum of $40,000 as the annual average of wages and salaries in the province for the year preceding that in which the determination is made bears to the annual average of wages and salaries for the year 1984; and the resulting figure is rounded to the nearest $100. (17) For the purpose of determining annual average of wages and salaries under Subsection (8), the Board may use data published or supplied by Statistics Canada. (18) Prior to 1986, the Act referred to $11,200 and 1972 as the factors in the formula for calculating the maximum.

For the maximum wage rates in force and the percentage used to calculate temporary and permanent disability payments, see below.

Date of Injury	Percentage Amount	Yearly Applicable
January 1, 1999 – December 31, 1999	75%	$57,500.00
January 1, 2000 – December 31, 2000	75%	58,000.00
January 1, 2001 – December 31, 2001	75%	58,500.00
January 1, 2002 – December 31, 2002	75%	59,600.00

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

The maximum wage rate is not subject to Consumer Price Index adjustments. Nor can a worker who is in receipt of the current maximum compensation benefits receive the benefit of such adjustments. However, if the maximum wage rate is increased in any year, workers injured in a prior year who were limited by the maximum compensation for that year can receive the benefit of any applicable Consumer Price Index adjustments occurring after the increase. Such adjustments are calculated using the previous maximum as a base and cannot at any time increase the worker's compensation above the current maximum.

Increases in the maximum wage rate do not have the effect of increasing the existing compensation being paid to workers whose payments have been limited

by the lower maximum existing in a previous year. An exception to this rule may occur when, on a reopening occurring more than three years after the injury, the Board exercises its authority under Section 32 to base compensation payments on the worker's earnings at the time of the reopening. (19)

Authority to approve increases in the maximum wage rate under Section 33 has been assigned to the President.

#69.10 Deduction of Pensions from Wage Loss

Section 31(1) provides as follows:

> "Where a worker is receiving compensation for a permanent or temporary disability, the worker must not receive compensation for a further or other disability in an amount that would result in the worker receiving in the aggregate compensation in excess of the maximum payable for total disability."

Where a worker is entitled to wage-loss payments at the current maximum, and is in receipt of a permanent disability pension under a previous claim, the pension is deducted from the wage-loss payments. If the wage-loss payments are less than the current maximum only the amount in excess of the maximum when the pension and wage loss are added together is deducted.

For calculating the amount of a deduction, the daily rate of the pension must be determined and then deducted from the daily rate of wage-loss compensation in the manner set out in #70.10.

The deduction made under Section 31 must be reviewed on each July 1 and January 1 following the injury. This is to allow for possible Consumer Price Index adjustments to the amount of the pension and the wage loss and, with regard to January 1, changes in the maximum wage rate. For the purpose of Section 31, the relevant maximum is the one applying in the year in which the wage-loss payment is being made.

For the deduction from wage loss of pensions awarded under the same claim, reference should be made to #70.00-70.20.

#69.11 Pension Cash Awards and Term Pensions

Section 31(2) provides that "Where a worker has received a lump sum in lieu of the periodic payments that otherwise would have been payable for a permanent disability, the worker is, for the purposes of subsection (1), deemed to be still in receipt of the periodic payments."

Where a worker is entitled to receive wage-loss benefits on a new claim and has received a lump-sum payment on any prior claim (in lieu of a monthly pension) with a monthly equivalent of $20.00 per month or greater at the time of commutation, the pension will be deducted only to the extent that it is necessary to ensure that the worker does not receive in the aggregate more than the current maximum.

In the case of a reopening of the same claim within three years, any previous lump-sum payment (in lieu of a pension) with a monthly equivalent of $20.00 per month or greater at the time of the commutation will be deducted from the current daily wage-loss payments. The same position exists in respect of reopenings of the same claim after three years where the claimant's pre-injury earnings are used to calculate benefits. Where, however, in the case of a reopening after three years, current earnings are used under the terms of Section 32(1), any previous lump-sum payment (in lieu of a pension) with a monthly equivalent of $20.00 per month or greater at the time of the commutation will be deducted in accordance with Section 32(2).

Lump-sum awards having a monthly equivalent of less than $20.00 per month at the time of the commutation will in all cases be ignored when paying wage loss on the future reopening of the same claim or when paying wage loss on a later new claim.

Where there is a recurrence after three years and a term pension remains applicable and is being considered for its significance under Section 32(2), the term pension should be converted to a notional life value for that purpose.

While the question whether a lump-sum payment is deducted is determined by its monthly equivalent at the time of the commutation, the amount actually deducted is the monthly equivalent at the time the deduction is made. The amount available for deduction includes Consumer Price Index adjustments which have occurred since the commutation was granted. An exception is made in respect of commutations granted prior to November 30, 1973. In those cases only the monthly equivalent at the time of the commutation can be deducted. Where in such a case, an award under Section 26 has been made, the amount available for deduction is computed by adding the current benefits under Section 26 to the monthly equivalent at the time of the commutation.

#70.00 AVERAGE EARNINGS ON REOPENED CLAIMS

#70.10 Disability Occurring Within Three Years of Injury

Where a claim is reopened for temporary total or temporary partial disability within three years of the date of injury (or the equivalent date in the case of occupational diseases), the wage rate set on the claim at the time of the injury is

the rate to be used. This could be either the original rate or the 8-week rate change figure if such an adjustment has occurred. Any pension awarded under the same claim is deducted from the amount of the payments. A pension that has been awarded on another claim is deducted only to the extent that the combined total of wage-loss and pension benefits exceeds the current maximum. Consumer Price Index adjustments are made if applicable. Section 32 has no application in these cases.

Where a partial disability pension is being paid on the same claim, the wage-loss payments are calculated as the difference between the total compensation benefits and the partial disability pension in the following manner.

1. The annual pension is calculated by multiplying the monthly figure by 12.
2. The annual pension is divided by the working days per year to obtain a daily rate.

   5-day week = 261 days
   5-1/2-day week = 287 days
   6-day week = 313 days
   7-day week = 365 days

3. The daily pension is deducted from the daily wage-loss payment. (20)

If an 8-week rate review has not already been carried out on the claim, it will be done by the Claims Adjudicator following the reopening when the total wage loss paid on the claim adds up to eight weeks.

The provision discussed in #67.10 may be applied, so that compensation is based on the claimant's earnings at the date of the reopening. Suppose, for example, a student with a part-time job is injured and the rate is set at the low rate of pay being earned at the time of injury. If this student should later graduate from school or university and enter the labour force on a permanent basis and be required to stop work for further treatment of the injury, wage-loss payments would not necessarily be based on the rate of pay at the time of injury.

#70.20 Reopenings Over Three Years

Section 32 of the *Act* provides as follows:

> "(1) For the purpose of determining the amount of compensation payable where there is a recurrence of temporary total disability or temporary partial disability after a lapse of 3 years following the occurrence of the injury, the board may calculate the compensation as if the recurrence were the happening of the injury if it considers that by doing so the compensation payable would more nearly represent the percentage of actual loss of earnings suffered by the worker by reason of the recurrence of the injury.

(2) Where a worker has been awarded compensation for permanent partial disability for the original injury and compensation for recurrence of temporary total disability under subsection (1) is calculated by reference to the average earnings of the worker at the date of the recurrence, the compensation must be without deduction of the compensation payable for the permanent partial disability; but the total compensation payable must not exceed the maximum payable under this Part at the date of the recurrence.

(3) Where more than 3 years after an injury a permanent disability or an increased degree of permanent disability occurs, the compensation payable for the permanent disability or increased degree of permanent disability may be calculated by reference to the average earnings of the worker at the date of the occurrence of the permanent disability or increased degree of permanent disability."

Section 32 of the *Act* gives the Board a discretion to determine compensation benefits on a reopening of a claim more than three years after an injury by reference to the worker's current earnings.

The guidelines set out below apply effective October 27, 1986. They apply in situations where there is a recurrence of temporary disability or an occurrence of or increase in a permanent disability over three years after an injury or disablement from occupational disease.

1. **Temporary Disability Occurring After Three Years Where the Claimant Is Employed**

(a) **Worker's Current Earnings Exceed the Rate Originally Set On the Claim**

Where the worker's earnings at the time of the occurrence of disability **exceed** the earnings rate originally set on the claim (or the 8-week review rate, if applicable) plus Consumer Price Index adjustments, section 32(1) is normally applied so as to treat the recurrence of disability as the happening of the injury. Wage-loss compensation is based on the worker's earnings immediately prior to the recurrence and, where there is an existing permanent partial disability pension granted in respect of the original injury, section 32(2) applies. Therefore, the pension is not deducted from the wage-loss benefits except to the extent that the combined total exceeds the maximum wage rate in effect at the time of the recurrence. (21) An 8-week rate review will be carried out if the disability following the reopening of the claim continues for that period. Any Consumer Price Index increases occurring in the six months following the recurrence will, by virtue of section

25(2), not be applicable to the wage-loss payments being made. (22)

(b) **Worker Is Employed at the Same Rate as Originally Set On the Claim**

Where the worker is employed at the **same rate** as originally set on the claim (or 8-week review rate, if applicable), the previous rate will be used plus applicable Consumer Price Index adjustments. The discretion contained in section 32(1) will not be exercised.

(c) **Worker Is Employed at a Lower Rate than Originally Set On the Claim**

Where the worker is employed at a **lower rate** than the rate originally set on the claim (or 8-week review rate, if applicable) plus applicable Consumer Price Index increases, a determination will be made as to the reason for the lower figure.

(i) **Reduced Earnings Due to Effects of the Injury or Disease Accepted On the Claim**

If it is determined that the reduced earnings level is due to the effects of the injury or disease accepted on the claim, the rate originally set on the claim (or 8-week review rate, if applicable) plus applicable Consumer Price Index adjustments will be used on the reopening. Care must be exercised in making this determination to ensure that consistency is maintained with prior decisions reached on the claim. If, for example, a prior decision has been reached that a pension or higher pension which the claimant asked for should not be awarded because the claimant was capable of undertaking certain occupations, it will not now be possible to conclude that the claimant's not being employed in those occupations is due to the effects of the injury.

(ii) **Reduced Earnings Due to Personal Choice**

If it is determined that the lower earnings level is due to a matter of personal choice on the part of the claimant, such as, for example, a voluntary change in lifestyle, the reduced earnings figure will be used on

reopening. Section 32 will be applied and the rules set out in (a) above will apply in relation to the reduced figure. If it is concluded that this voluntary or elective change in earnings status is indicative of the future, no 8-week rate change on the basis of prior earnings will be carried out should the disability following reopening extend to that point.

(iii) **Reduced Earnings Due to Employment Situation**

If it is determined that the reduced earnings at the time of the reopening are due to employment difficulties occasioned by economic circumstances, section 32 applies and the recurrence of disability is treated as the happening of the injury. Where there is an existing permanent partial disability pension granted in respect of the original injury, section 32(2) applies and the pension is not deducted from the wage-loss benefits except to the extent that the combined total exceeds the maximum wage rate in effect at the time of the recurrence. The current rate of earnings will be used for the first eight weeks at which point a review is carried out. Since the 8-week review permits a consideration of the one year's, three or five years' earnings prior to the injury, it will have the effect of adjusting for the long term any temporary aberrations in earnings capacity caused by economic fluctuations.

Any Consumer Price Index increases occurring in the six months following the recurrence will, by virtue of section 25(2), not be applicable to the wage-loss payments being made.

2. **Temporary Disability Recurring After Three Years Where the Claimant Is Unemployed**

Where the worker is unemployed at the time of the reopening, a determination will be made of the reasons for this.

(a) **Where Unemployed Status Is Due to the Effects of the Injury or Disease**

If it is determined that the unemployed status prior to the recurrence is due to the effects of the injury or disease accepted on the claim, the rate originally set on the claim (or the 8-week review rate, if applicable) plus applicable

Consumer Price Index adjustments will be used. The discretion in section 32 will not be exercised. As in 1(c)(i) above, care must be exercised to ensure that the determination is consistent with prior decisions on the claim.

(b) **Where Unemployed Status Is Not Due to Effects of the Injury or Disease**

If it is determined that the worker's unemployed status prior to the recurrence is not due to the effects of the injury or disease accepted on the claim, no wage-loss benefits are payable unless the disability following reopening will produce a potential for loss of income by removing the worker as a viable entity in the labour force. In the latter case, benefits will be paid on the basis of the wage rate originally set on the claim (or the 8-week review rate, if applicable) plus applicable Consumer Price Index adjustments. In determining whether there is a "potential loss", the following are among the questions that might be considered.

(i) Was the claimant's unemployment a matter of personal choice?

(ii) Does the claimant's lifestyle render it unlikely that he or she will, in practice, obtain employment? For example, if the claimant has moved to a remote area where there are virtually no employment opportunities, this would indicate that there was no potential loss.

(iii) Are there any other health conditions or personal problems that limit the possibility of employment?

(iv) Was the worker being paid Employment Insurance benefits? Since the payment of such benefits requires a confirmation that the worker is fit for work, this would be an indicator that there was a potential loss.

(v) Has the worker been making an active, ongoing, job search? Has the worker registered with the Canada Employment and Immigration Commission?

(vi) Has the worker maintained union status, remained available for dispatch to jobs, been dispatched to jobs or declined offers of dispatch?

(vii) Was the worker listed as seeking employment by the Ministry of Social Services?

3. **Permanent Disability Occurring or Increasing More Than Three Years After Injury**

The rules set out above in relation to wage-loss benefits are, in general, equally applicable to permanent disability pensions. These rules have the effect that in one situation no wage-loss benefits are paid, notably when the worker is unemployed otherwise than through the effects of the injury and it is determined that there is no potential loss of earnings. A pension assessed on a physical impairment basis under section 23(1) of the *Act* should, however, be paid in that situation and (subject to any appropriate wage rate review being carried out) calculated on the basis of the wage rate originally set on the claim plus applicable Consumer Price Index adjustments. Pensions are distinguishable from wage-loss benefits since they are concerned with the long term as opposed to the current situation. A permanent disability award is payable under section 23(1) for significant impairments even though the worker has returned to work with no loss of earnings and may not have a loss of earnings in the future. The section directs that the pension is payable for life and appears to rest on an assumption that over the many years ahead some loss will on average be experienced. It follows that, just because a person is unemployed and does not now foreseeably have an actual loss of earnings, it does not mean that the person should not receive an award under section 23(1). However, the situation is different for projected loss of earnings awards under section 23(3). Since that assessment aims to predict the worker's actual loss of earnings over the future, no award can be made when the worker is unemployed for reasons unrelated to the injury and it is determined that there will not be a potential loss of earnings.

4. **Prior Occasion When Section 32 Was Applied**

Where, on a previous reopening of the claim, section 32 or its predecessor has been used to base compensation on the current earnings, any rate resulting from the application of that section is ignored for the purposes of a later reopening.

5. Where, according to the guidelines set out above, compensation would normally be based on the worker's pre-injury earnings, but it is found impossible or impractical to obtain those earnings, section 32(1) or (3) may be applied, unless this will result in a rate of compensation significantly less than that to which the pre-injury earnings would probably have entitled the worker. In the latter case, a reasonable estimate should be made of the worker's probable pre-injury earnings.

EFFECTIVE DATE: March 3, 2003 (as to deletion of references to recurrence and new injury)
APPLICATION: Not applicable.

#70.30 Pension Cash Awards and Term Pensions

The Board's policy with respect to a reopening of claims after three years, where a pension cash award or term pension is involved, is as described in #69.11.

#71.00 COMPOSITION OF AVERAGE EARNINGS

A worker's average earnings is normally composed of wages or salary. Set out below are some other items which may have to be included or excluded.

#71.10 Extraordinary or Irregular Wage Payments

Such items as commission, piecework, bonus, tips and gratuities must be included in a worker's average earnings. This may involve basing wage-loss payments from the outset of the claim on the worker's earnings over a longer period, usually one year, rather than on the rate of pay at the date of injury.

#71.11 Overtime

Only regular overtime is covered when compensation is based on the rate of pay at the date of injury. If there has been significant amounts of occasional or irregular overtime, wage loss at the outset of the claim will normally have to be based on the worker's earnings over a longer period rather than on the rate of pay at the date of injury.

#71.12 Severance or Termination Pay

The Board does not assess firms for payments made as a result of severance, whether by collective agreement or other obligations.

In situations where a severance payment is involved, in setting a long-term wage rate on a claim at the 8-week point of disability, an Adjudicator will only include assessed payments in computing annual earnings.

#71.13 Salary Increases

In calculating average earnings, no regard will normally be paid to salary increases or promotions which a worker might have received if the injury had not occurred. The only exception is where a salary increase is awarded which is retroactive to before the injury.

#71.20 Fringe Benefits

The Board does not include fringe benefits as a component of average earnings. Fringe benefits include, but are not limited to, employment payment for or contributions to CPP, Employment Insurance, retirement, pension, health and welfare, life insurance, training, or other employee or dependent benefit plans.

Where wages paid to a worker are supplemented by an additional amount representing statutory holiday payments or vacation allowances, these additional amounts are included in setting the wage rate on a claim. This practice normally applies to construction workers. Recognition is also given to fixed allowances such as payments to carpenters who are paid a 40¢ per hour travel allowance. This is a taxable allowance and is not an actual cost reimbursement and as such is included in the wage rate.

#71.21 Room and Board

The dollar value of room and board is included in average earnings, unless the worker continues to receive room and board during the disability. However, any payment by the worker for the continuation of room and board while disabled can be included in average earnings.

A distinction should be made between room and board which is provided in total or in part by an employer as the remuneration for services rendered and a situation where a worker incurs a refundable expense. An example of the latter type of situation occurs where an official of a company has to make a business visit out of town and incurs the cost of an hotel and meals. On return, the official submits an expense account and the actual expenses are refunded by the employer. In such situations the Board does not consider the expenses when computing a worker's wage rate.

These principles apply to resident caretakers of apartment buildings. The value of any free or subsidized apartment provided with the job must be considered when determining average earnings. Where specific evidence is not available, the Minimum Wage Order in respect of resident caretakers, made under the *Minimum Wage Act*, may be referred to when valuing an apartment.

Where a worker continues to be provided with room and board during the disability without extra charge and the worker's salary is continued by the employer, any reimbursement to the employer carried out by the Board will, subject to the maximum wage rate under the Act, include the value of room and board as well as the worker's salary. Where, however, during a period of disability, the worker is provided with free room and board but is not being paid full salary, there will be no reimbursement made to the employer for the value of the room and board. (23)

#71.30 Strike Pay and Unemployment Insurance Payments

Strike pay and Employment Insurance payments are not included when calculating a worker's earnings over a period of time.

The same rule applies to supplementary unemployment benefits paid by an employer pursuant to a collective agreement and to any contributions made by the employer to the fund set up to make those payments.

#71.40 Property Value Losses

No account will be taken of losses in property values alleged to be the result of the work injury, for example, where the injured person is disabled from working on and improving land which the person owns or there is a loss of goodwill in the business because of an inability to work in it.

#*71.41 Payments in Respect of Equipment*

Any portion of the wages paid to a worker which represents rental of equipment supplied by her or him is excluded from average earnings. This does not apply to a worker who is simply providing one power saw or other hand tools.

For short-term disability claims and the first eight weeks on long-term disability claims, the gross earnings will be determined in the normal way. The gross figure will be converted to net wages by applying one of two percentages. These are:

(a) **Medium Equipment** – Equipment – 40%
– Wages – 60%

Examples: Motor vehicles used for pilot car or local delivery services, minor excavating equipment, e.g. two-wheel drive agriculture-type tractors, complete with backhoe attachments and/or front-end loader attachment.

(b) **Heavy Equipment** – Equipment – 75%
– Wages – 25%

Examples: Logging trucks, skidders, bulldozers, line haul trucks.

In setting the rate after eight weeks of disability on a claim (including a fisher's claim) or in relation to a permanent disability pension, the gross earnings will also be determined in the normal way. When asked to provide earnings information, the claimant will also be asked to list the purchase price of the vehicle, vessel or piece of equipment. In deducting operating costs or expenses from the gross figure to obtain net earnings, the capital cost allowance or depreciation figure listed on the claimant's data will not be used. In place of this figure, a percentage will be selected from the straight-line depreciation tables set

out below which most closely represents the vehicle, vessel or piece of equipment involved. This percentage will then be applied to the purchase price of the item and the resulting figure will, along with the other operating costs or expenses, be deducted from the gross to compute the net earnings figure.

Equipment Type	Annual Rate
Road Construction	
Track-type – Lesser than 200 HP	11%
Tractor – Greater than 200 HP	6%
Motor Grader	7.5%
Excavator	11%
Track Loader	11%
Backhoe (R/T Tractor)	18.5%
Logging	
Track-type – Lesser than 200 HP	11%
Tractor – Greater than 200 HP	6%
Skidder	11%
Loader – Boom Type	7.5%
Loader – Front-end Type	11%
Log Truck and Trailer	8%
Transportation	
Line Haul Tractor	10%
5-ton Truck	10%
1-ton Truck/Van	8%
Automobile	12.5%
Gravel Truck	17%
Fishing	
All Vessels	7.5%

#71.50 Payments to Substitutes

If a disabled worker pays another person to do the job and the worker performs no functions, a refund can be made to the worker of 75% of the amount paid. This refund cannot exceed the wage-loss compensation that would otherwise have been paid to the worker or the maximum amount of compensation. The substitute must normally provide written confirmation of the amounts paid to him.

A claimant may be partially able to perform the normal work or work full-time at other types of work, but pay a substitute to carry out jobs which the claimant is

unable to do. Compensation will still be paid in respect of the payment to the substitute but only to the extent of the difference between the value of the work being performed by the claimant and the lesser of his pre-injury earnings and the statutory maximum. Where the value of that work exceeds pre-injury earnings or the statutory maximum, no compensation is paid.

Where the claimant is a principal of a limited company, the amount paid to a substitute may be one indication of the principal's pre-injury earnings level if these earnings are not otherwise clearly ascertainable because, for example, earnings have consisted of sporadic withdrawals from the income or profits of the corporation. If the principal continues to work in the business after the injury while employing a substitute to carry on part of the pre-injury functions, the amount paid to the substitute may, in comparison with the pre-injury earnings, be a factor in computing the value of the principal's post-injury work. Regard would, however, also have to be had to the nature and extent of the principal's activities after the injury compared with before the injury and the continued income received from the business after allowing for the costs of operation.

Where a claimant has personal optional protection, benefits are calculated without regard to the fact that the claimant is employing a substitute to do all the pre-injury work. If, however, the claimant is still doing part of the work, or otherwise participating in the operation of the business, the payment to the substitute may be a factor in determining the value of the claimant's post-injury work for the purpose of computing temporary partial disability benefits under Section 30.

#71.60 Government Sponsored Work Programs

A variety of payment systems are currently in use for work programs, such as:

1. The simple continuation of Employment Insurance, Welfare or other benefits.

2. A "top-up" of Employment Insurance, Welfare or other benefits.

3. Full payment by the employer, subsidized either in whole or in part from Employment Insurance, Welfare or other government funds.

In cases of this type, the rate for compensation purposes for the initial eight weeks of disability is calculated on the basis of the total dollar amount being paid to the claimant either by the employer or the sponsoring government agency or a combination of either. The procedures for computing the long-term earnings at the 8-week rate change or for pension purposes will follow the standard procedures established for all other claims.

This procedure applies to injuries incurred on or after September 24, 1986.

NOTES

(1) See #69.00
(2) See #67.20
(3) See #34.40
(4) See #68.00
(5) See #34.20
(6) See 20:50:00 Assessment Policy Manual
(7) See #34.20; #35.23; #37.20; #39.60
(8) See #55.26
(9) See #40.00
(10) See #70.20
(11) S.33(2); See 20:10:30 Assessment Policy Manual
(12) See 20:10:40 Assessment Policy Manual
(13) See #66.12
(14) See #66.10; #67.20
(15) See #66.12; #67.21
(16) See #37.20; #39.60
(17) S.33(10)
(18) S.33(9)
(19) See #70.20
(20) See #69.00
(21) See #69.10
(22) See #51.11
(23) See #34.40

CHAPTER 10

MEDICAL ASSISTANCE

#72.00 INTRODUCTION

Section 21(1) of the Act provides in part as follows:

> "In addition to the other compensation provided . . ., the board may furnish or provide for the injured worker any medical, surgical, hospital, nursing and other care or treatment, transportation, medicines, crutches and apparatus, including artificial members, that it may consider reasonably necessary at the time of the injury, and thereafter during the disability to cure and relieve from the effects of the injury or alleviate those effects, and the board may adopt rules and regulations with respect to furnishing health care to injured workers entitled to it and for the payment of it."

Under Section 21, the Board is responsible for the cost of health care benefits for compensable injuries and occupational diseases. This includes necessary hospitalization, treatment provided by recognized health care professionals, prescription drugs and necessary medical appliances.

#73.00 RIGHT OF WORKER TO HEALTH CARE BENEFITS

Health care benefits are provided on accepted claims for compensation from the date of injury. They are provided even though the worker is not disabled from earning full wages at the work at which he or she was employed. (1)

Where a worker who is not disabled from working loses time from work to attend treatment or be examined, the worker may be eligible to receive income-loss payments equivalent to wage-loss benefits. This entitlement is fully explained in #83.13.

#73.10 Prior to Adjudication

A worker will often receive treatment prior to the adjudication of the claim. If this treatment takes place at the Board's Rehabilitation Centre, the Board will meet the cost, whether or not the claim is later accepted. With regard to treatment received elsewhere, the costs are paid only when the claim is accepted. (2)

The Board may pay for medical examinations or consultations on an investigative basis to assist in the adjudication of a claim. (3) However, if the investigation shows that the claimant's condition is not compensable, the Board

will not pay wage-loss for the period of the investigation simply because it has paid for health care benefits.

#73.20 Duration of Medical Assistance

Coverage for necessary health care continues for as long as the worker continues to experience the effects of a compensable injury or occupational disease, notwithstanding that he or she may not be disabled from working or may be retired from the workforce.

#73.30 Suspended Claims

No authorization for treatment may be given and no health care benefits are paid for the time that a claim is under suspension. If the claim is subsequently accepted, health care benefits incurred during the suspension are then paid.

#73.40 Approved Health Care Plans/Canada Shipping Act

Section 21(4) provides that "Where a worker received, before April 1, 1972, health care under

(a) the *Canada Shipping Act* (Canada); or

(b) a health care plan approved by the board,

the worker is entitled to receive, in accordance with this section, additional health care."

As a result of this provision, health care benefits can be provided whether or not the worker is also entitled to such benefits under the *Canada Shipping Act*.

The Act previously allowed for the provision of health care benefits by employers under plans approved by the Board. The plans have now all been discontinued. Under the cancelling agreements, some of the employers are required to pay health care benefits in respect of injuries which occurred prior to the date of cancellation.

#73.50 Out-of-Province Treatment

#73.51 Injury Outside the Province

For employees of railways, transportation companies, trucking companies, and other personnel whose business may take them to other provinces, emergency medical treatment is allowed at the rates applicable in the locality where it is given. However, this is only for such period as the worker's condition prevents a return to British Columbia. If it appears that treatment will be prolonged, consideration will be given to arranging the return of the worker to British Columbia.

#73.52 Worker Injured Near the Provincial Border

Where the worker is a resident of British Columbia and the nearest health care available is in a province, state or territory adjacent to British Columbia, health care benefits may be paid at the rates applicable in that jurisdiction for treatment of short-term disabilities. Subsequent early transfer to British Columbia will be considered in more serious cases.

If, however, a worker injured near the provincial border bypasses available facilities in British Columbia, and by way of personal choice elects to receive treatment outside the province, the Board will not pay in excess of British Columbia rates for that treatment. For instance, this could apply if a worker resident outside the province, but working and injured within its borders, bypassed available and convenient British Columbia facilities and used out-of-province facilities near home.

#73.53 Worker Leaves the Province to Obtain Specialized Treatment

It may be necessary to transfer a patient from British Columbia to another province or country for specialized treatment. In such cases, the rates applying in the area where the specialized treatment is carried out are payable, if the transfer is authorized by the Board.

#73.54 Worker Voluntarily Leaves the Province

If a worker during treatment desires to leave British Columbia, either temporarily or permanently, the worker is required to discuss the treatment ramifications with the Board. Where leaving the province may impede the worker's recovery, the worker will be discouraged from doing so, and benefits may be suspended pursuant to #78.12 or #78.13.

The Board will generally not pay in excess of British Columbia rates for health care rendered outside the province to a claimant who has voluntarily left the province.

#74.00 PHYSICIANS AND QUALIFIED PRACTITIONERS

A claimant is entitled to the services of a physician or qualified practitioner. A "physician" is any person registered under the *Medical Practitioners Act* and a "qualified practitioner" is a person registered under the *Podiatrists Act*, the *Chiropractors Act*, the *Dentists Act*, or the *Naturopaths Act*. (4) Thus, the services of medical practitioners, podiatrists, chiropractors, dentists, and naturopathic physicians are covered by the Act. Under Section 21, the Board reserves the right to determine if any particular form of treatment, or provider of treatment, is one that should be recognized for the care of a claimant.

#74.10 General Position of Physicians and Qualified Practitioners

Physicians and qualified practitioners are required to submit reports to the Board regarding the nature of the worker's condition, the treatment program, the progress of the claimant and to advise and assist workers in making application for compensation. (5)

Every physician or qualified practitioner who is authorized to treat an injured worker is subject to like duties and responsibilities, and any health care furnished by such person shall be subject to the direction, supervision, and control of the Board. (6)

Physicians, qualified practitioners, or other persons authorized to render health care shall confine their treatment to injuries to the parts of the body they are authorized to treat under the statute under which they are permitted to practice, and the giving of any unauthorized treatment is an offence. (7) The maximum fine for committing this offence is set out in Part 1 of Appendix 6 to this manual.

Where, in a case of emergency, or for other justifiable cause, a physician or qualified practitioner other than the one provided by the Board is called in to treat the injured worker, and if the Board finds there was a justifiable cause and that the charge for the services is reasonable, the cost of the services shall be paid by the Board. (8)

#74.11 Medical Negligence or Malpractice

During the progress of a claimant's file, information may come to the attention of Board employees that would lead them to conclude that there was prima facie evidence of medical malpractice or negligence. This may come from the perusal of a single file or the perusal of a series of files where claimants have been treated by the same physician. The following action should be taken in these cases:

1. Where this is brought to the attention of a Board employee or a Board physician, it shall be reported to the Vice-President, Medical Services Division.

2. The Vice-President, Medical Services Division will review the case, together with a committee composed of the following members:

   (a) The Board's General Counsel, or nominee;

   (b) The Director, Medical Services Department;

   (c) The Director, Rehabilitation Centre.

3. The committee will forward to the President a recommendation for action in cases where it is felt that medical malpractice or negligence may have occurred. The President will determine whether to proceed with an action. The claimant will be advised of the President's decision with reasons.

#74.20 Chiropractors

#74.21 Duration of Treatment

After eight weeks of treatment by a chiropractor, or earlier if there is any ground for suspecting that the claimant is not receiving proper treatment, the file must be referred to a Board Medical Advisor for review. The Board Medical Advisor will decide whether a continuance of treatment by the chiropractor should be authorized. It is necessary when such a request is received that the medical factors be considered and the various options evaluated. The main options which should be considered in order of preference are:

1. Have the claimant examined at the Board.
2. Refer the claimant for an orthopaedic or other appropriate specialist consultation.
3. Agree to an extension.

Giving preference to an examination by a Board Medical Advisor is simply an effective method of determining whether options 2 or 3 are necessary or appropriate, or whether some other approach or decision is indicated.

The third option is generally limited to situations where recovery appears imminent. The Board Medical Advisor should be satisfied that the worker's condition is improving. The duration of additional chiropractic treatment must be clearly designated, including the frequency of the treatments. Any extension should be limited to a maximum of four weeks. Where a request is received for an extension beyond this point, approval cannot be granted unless an examination is carried out by a Board Medical Advisor or there has been a specialist consultation. It is expected that extensions beyond 12 weeks would only occur in rare and unusual circumstances.

The reasons for accepting or denying a request for an extension of chiropractic care must be recorded on the claim file and since it is a decision that is reviewable by the Review Division, it must be communicated in writing by the Adjudicator to the claimant and the chiropractor. When recording their opinions on claim files, Board Medical Advisors should clearly define the reasons in support of their recommendations by outlining in what way an extension may produce an improvement in the worker's condition, or alternatively, why further treatments are likely to be ineffective. Under no circumstances should Board Medical Advisors make statements in the claim file such as, "I don't think this should be denied unless it is too frequent" or "I have no objection to chiropractic treatment if the worker thinks it is going to help."

Situations are occasionally met where claimants receive chiropractic treatments on a long-term basis (for example, one treatment per month for six to twelve months). Such treatments are probably more in the nature of preventative measures or as a means of forestalling future problems. The purpose of section 21 of the *Act* is to provide health care benefits for the treatment of injuries or occupational disease. As such, long-term chiropractic manipulation of this type will not be considered acceptable.

As a general rule, the Board will not pay for more than one treatment by a chiropractor per day. Any exception to this rule should normally be authorized beforehand by the Board. No exception will be allowed on the grounds that the additional treatment is needed to compensate for the bad effects of the journey to the chiropractor when, by seeking treatment from another chiropractor or different type of practitioner at a different location, the journey could have been avoided.

The Board will also not pay for daily treatment nor for house visits after the initial treatment unless the necessity is clearly indicated.

EFFECTIVE DATE: October 1, 2007 – Revised to delete references to memos and memorandums.

HISTORY: March 3, 2003 – consequential changes as to references to review

APPLICATION: Applies on or after October 1, 2007

#74.22 Scope of Chiropractic Treatment

The Board has established the guidelines set out below regarding the acceptability of chiropractic treatment.

1. Where chiropractic treatment is directed at the spinal column in respect of complaints in the extremities for which a claim has been accepted, the Board may refuse responsibility for the treatment if it concludes that the injury at work did not affect the spine, but was to the extremities only.

2. Where chiropractic treatment is directed at the spinal column for problems in an extremity and it is accepted that the work injury caused the condition of the spinal column, the treatment may be acceptable if it is concluded that the problem in the extremity arose from that condition.

3. Treatment by a chiropractor to the spine or any other articulations of the body must be reasonable and acceptable treatment for the medical problem experienced by the claimant.

4. Chiropractic treatment to the spinal column is not acceptable where:

   (a) there is clinical evidence to suggest nerve root pressure with definite and progressive neurological findings; or

   (b) there are fractures, dislocations, underlying bony pathology, or other conditions requiring immediate surgical or medical treatment.

5. Chiropractic treatment to the articulations of the extremities is not acceptable in respect of:

   (a) fractures, dislocations, underlying bony pathology or other conditions requiring immediate surgical or other medical treatment;

   (b) soft tissue injuries, including muscle contusions, hematomas, infectious conditions, tenosynovitis, tendinitis, bursitis, epicondylitis, carpal tunnel syndrome and Dupuytren's contracture, but excluding minor sprains and strains arising from an articular injury.

6. Prior to refusing or terminating authorization for chiropractic treatment, the Board Medical Advisor will be consulted and, in appropriate cases, the Board's Chiropractic Consultant.

7. A chiropractor who has been treating a worker will be notified of any decision by the Board to terminate its authorization for that treatment under the terms of this decision.

#74.23 *Examination by the Board*

The Board may call a worker in for a medical examination at any time. (9) Where there is no appreciable improvement during treatment, the chiropractor may ask the Board to call the worker in for examination.

When a worker who has been treated by a chiropractor has been examined at the Board and referred by a Board Medical Advisor to a medical consultant, the chiropractor must be notified by letter.

#74.24 *Consultation with Another Chiropractor*

On a problem case, a chiropractor may ask for consultation with another chiropractor. This may be allowed, but it must be authorized by a Board Medical Advisor. The responsibility for obtaining permission rests equally on the attending chiropractor and the consultant before the consultation is carried out, otherwise, the consultation fee may not be allowed. (10)

#74.25 Physiotherapy

Physiotherapy cannot be prescribed by a chiropractor at the Board's Rehabilitation Centre or elsewhere.

Concurrent treatment is discussed in #74.60.

#74.26 Belts and Back Supports

The supplying of belts and back supports cannot be granted on the order of a chiropractor, but may be approved by a Board Medical Advisor. (11)

#74.27 X-rays

X-rays may be taken for the purpose of assisting a chiropractor in the treatment of a worker, subject to the following:

1. The Board will not pay for full-length views of the spine.

2. With respect to x-rays of the affected anatomical areas of the spine, the minimum examination should be as follows:

    (a) Cervical spine – A.P. and lateral as well as an open-mouth view of the odontoid. Oblique views to be added as indicated.

    (b) Dorsal spine – A.P. and lateral full-length views with additional coned views of areas not clearly shown on the two primary views.

    (c) Lumbar spine – A.P., lateral, and a coned lateral view of the lumbosacral junction (oblique views to be taken in addition, if indicated).

Payment will not be made for x-rays of non-interpretable quality, for x-rays of areas of the body not injured, and for excess, or duplication of, x-rays.

Complete x-ray reports, signed by the chiropractor, must be submitted within seven days. The x-rays should be available to the Board on request.

#74.30 Dentists

The Health Care Benefits Department accepts responsibility for dental repair for damage caused by compensable personal injury or occupational disease. Payments are based on the fee schedule approved by the Board. Prior to commencing the work, a practitioner should submit an estimate to the Board outlining the proposed treatment. Appropriate authorization will then be given to the practitioner.

Where there are two equally functional treatment plans, the Board authorizes the plan that is expected to be the least costly in the long term. If a worker declines the treatment plan authorized by the Board and proceeds on another treatment plan, the coverage will not exceed the amount of payment that would have been made for the authorized treatment plan.

Where a claim is submitted for work-caused damage to dentures, the claim is adjudicated under Section 21(8)(b) of the Act rather than Section 5 or 6 of the Act. This imposes different requirements for coverage. Further details are contained in #23.00 to #23.70.

Claims for damage to crowns and fixed bridgework are adjudicated as personal injury under Section 5(1) (see #13.00) rather than Section 21(8)(b) of the Act as crowns and fixed bridgework are regarded as part of the natural anatomy.

#74.40 Naturopathic Physicians

After eight weeks of treatment by a naturopath, or earlier if there is any ground for suspecting that the claimant is not receiving proper treatment, the worker's claim must be referred to a Board Medical Advisor. The Board Medical Advisor may take any of the courses set out in #74.21.

The Board will not pay for house visits after initial treatment, unless the necessity is clearly indicated.

Fees may be paid for simple laboratory procedures such as hemoglobin, erythrocyte sedimentation rate and urinalysis. The Board may also accept fees from a medical laboratory for tests related to the condition under treatment incurred on the worker's behalf.

The Board may accept the costs of normal services from radiologists who provide this service on behalf of injured workers to naturopaths.

The Board may call a worker in for examination at any time. Where there is no appreciable improvement during treatment, the naturopathic physician may ask the Board to call the worker in for examination. (12)

#74.50 Selection of Physician or Qualified Practitioner

Section 21(7) of the Act provides that "Without limiting the power of the board… to supervise and provide for the furnishing of health care in every case where it considers the exercise of that power is expedient, the board must permit health care to be administered, so far as the selection of a physician or qualified practitioner is concerned, by the physician or qualified practitioner who may be selected or employed by the injured worker."

Subject to the Board's overriding supervisory power, this provision entitles the claimant to select his or her own practitioner. It should be noted that:

1. The section makes no distinction between the original selection and the changing of a practitioner.

2. The section makes no distinction between a practitioner qualified under the *Medical Practitioners Act* and one qualified under the *Podiatrists Act*, the *Chiropractors Act*, the *Dentists Act* or the *Naturopaths Act*, provided that the practitioner accepts Board patients and the appropriate fee schedule.

In certain situations, the Board may object to the selection made by the claimant, and may object to a change of practitioner. For example, the Board may be likely to object if it appears that the claimant is shopping around to find the practitioner who is thought likely to write the most favourable report. On the other hand, the Board will not object, either to an original selection or to a change, simply on the ground that it does not think the claimant is making the wisest choice, or because the claimant's judgment in the selection differs from the judgment that the Board would itself have made.

Where a worker wishes to make a change of physician or qualified practitioner, the following guidelines apply:

1. Where a worker moves, a new physician or qualified practitioner may be selected in the new community without prior permission from the Board.

2. Where a worker receives emergency treatment from a physician who is not the family physician, the worker may transfer to the family physician.

3. A worker may wish to transfer because of a loss of rapport with his or her attending physician, or because of a preference for a type of treatment available from a different type of practitioner. Where it comes to the attention of the Adjudicator that a worker has made or plans to make a change of this kind, the matter will be referred to a Board Medical Advisor. The change will be permitted unless the Board Medical Advisor concludes that it is likely to be harmful, or so medically unsound that it ought to be prohibited.

4. Where it appears that the worker is shopping around for a most favourable medical report, the matter should be referred to a Board Medical Advisor to consider whether an examination at the Board would be appropriate.

5. If it appears that a worker is making multiple changes of physician or qualified practitioner, the matter will be referred to a Board Medical Advisor to consider whether a rational treatment program is being followed.

If the Board Medical Advisor, or Rehabilitation Centre Physician concludes that a change of physician or qualified practitioner should be refused, the decision must be communicated to all physicians and qualified practitioners concerned, as well as to the worker. The physician or qualified practitioner to whom the refusal relates will be notified that the Board will honour an account for treatment up until the date of the advice, but will not accept responsibility for treatment beyond that date.

Any decision to refuse or terminate treatment by a "qualified practitioner" is not legally defensible if it rests on the general objection to the treatment of any patient by that kind of practitioner. Any decision not to allow a claimant the "qualified practitioner" of choice must be justified by a judgment made in the particular case that the selection would be medically unsound by reason of circumstances relating to that particular case.

A Board Medical Advisor or Rehabilitation Centre Physician may arrange for the claimant to be referred to a specialist, however, the worker is not forced to accept treatment he or she does not wish to receive nor treatment from a doctor against whom the worker has some objection.

A claimant cannot attend a doctor whose right to render health care has been cancelled or suspended under the provisions referred to in #95.30.

#74.60 Concurrent Treatment

The general view of the Board is that a worker should be under treatment by only one physician or other qualified practitioner at a time.

There are cases, however, where concurrent treatment may be deemed acceptable. For example, the same disability may require treatment by a general practitioner and a specialist, by two or more specialists, or the worker may benefit from treatment by a qualified practitioner with concurrent monitoring by the attending physician.

Where reports indicate a worker is receiving concurrent treatment, the claim will be referred to a Board Medical Advisor or Rehabilitation Centre Physician for review. Where the Board Medical Advisor or Rehabilitation Centre Physician conclude concurrent treatment is reasonable, approval will be granted.

Concurrent treatment will not be refused by the Board simply because it is inconsistent with a rule or policy of a professional organization.

If approval for concurrent treatment is denied, in those cases where medical reports have been submitted within a reasonable time, corresponding health care benefit accounts will be paid to the date of the written notification.

#75.00 HEALTH CARE RENDERED BY PERSONS OTHER THAN PHYSICIANS OR QUALIFIED PRACTITIONERS

Persons other than physicians or qualified practitioners may be authorized to render health care, for example, optometrists, dental mechanics, nurses and physiotherapists.

#75.10 Physiotherapists

Physiotherapists, who are members in good standing of the Canadian Physiotherapy Association or the British Columbia Association of Physiotherapists in Private Practice, may provide injured workers the specific types of treatment they are authorized by statute to render.

#*75.11 Physiotherapy at the Boards Rehabilitation Centre*

The Board may admit workers to the Rehabilitation Centre prior to the initial adjudication of their claims. (13) In third party claims however, a worker has no right to compensation until the worker elects to claim compensation. (14) In such cases the injured worker will not be admitted to the Rehabilitation Centre for treatment until he or she has so elected.

In cases when a request is received for admission to the Rehabilitation Centre for treatment where wage-loss benefits and/or health care benefits have previously been terminated, the decision regarding reopening must be made before admission is allowed.

In order to control absenteeism at the Rehabilitation Centre, the following policy based on Section 57(2) of the *Workers Compensation Act* has been adopted:

1. Each claimant on the original admission to the Rehabilitation Centre will be provided with a copy of notice summarizing this policy.

2. A notice to like effect will be posted on notice boards throughout the Rehabilitation Centre and Residence.

3. All absences, where known in advance, must have the prior approval of the Adjudicator before wage-loss payment may be made.

4. All absences resulting from sickness must be supported by a doctor's certificate before wage-loss payment may be made.

5. Adjudicators will have the discretion to authorize the payment of wage loss for an absence where no prior approval has been obtained or no doctor's certificate has been produced, but where, however, the special circumstances of the case support the maintenance of wage-loss payments.

6. Adjudicators must approve requests by claimants to be excused treatment during the course of a day. If the interruption of treatment is for medical reasons, the advice of a Rehabilitation Centre Physician or Rehabilitation Centre Nurse should be obtained by the Adjudicator before permission is granted.

7. All claimants returning from an absence due to an illness must be examined by either a Rehabilitation Centre Physician or Rehabilitation Centre Nurse prior to resuming their treatment program.

#75.12 Physiotherapy Given Privately

The following policy guidelines now apply for all Workers' Compensation Board claimants with the exception of paraplegics and quadriplegics.

1. Physiotherapy prescribed by the attending physician may be continued up to a maximum of **eight weeks** per case.

2. Such physiotherapy treatment shall not exceed one treatment per day.

3. Such physiotherapy shall be rendered by a chartered or registered physiotherapist.

4. The attending physician and the physiotherapist are required to be in communication regarding treatment progress.

5. In cases where the attending physician considers that physiotherapy should continue beyond eight weeks, prior authorization must be obtained from a Board Medical Advisor. This may be done by writing or telephoning the Board. At the time the authorization is given, the period of additional treatment will be specified (up to a maximum of eight weeks additional).

6. Where it is not feasible for the attending physician to obtain prior authorization, the request shall be submitted by the attending physiotherapist.

7. The physiotherapist may also communicate with the Board concerning patient progress. Such communication may be in the form of a letter or copies of progress reports sent to the physician.

8. Any case requiring physiotherapy treatment in excess of 16 weeks total accumulative amount shall be referred to the appropriate Board Medical Advisor/Consultant for consideration of approval to continue beyond this interval.

#75.20 Nurses

For seriously ill or injured workers who need additional nursing service, the necessary nursing service is determined and provided by the hospital. The Board is not responsible for payment of special duty nursing fees. If the worker or the worker's family desire to have a special nurse in attendance, the cost of employing such special nursing should be met by the worker. If the condition requires additional nursing service, the physician should indicate to the hospital the service necessary and discuss with the hospital any question about these requirements as this matter is outside the jurisdiction of the Board.

Temporary home nursing care is covered where it is specifically required because of the nature of the compensable medical condition. Where care is required permanently, the costs are covered under a personal care allowance (see #80.00).

When a registered nurse is required as nursing escort during emergency transportation, Registered Nurses Association fees will be paid, as well as the nurse's expenses.

Reports received from Canadian Red Cross Society Outpost Hospital nurses can be accepted in lieu of medical reports if there is no physician in the immediate area.

#75.30 Dental Mechanics

The fees paid to Dental Mechanics cover such necessary reports as the Board may require.

Reports submitted should state clearly the exact extent of dental damage occasioned by the accident, the method of restoration and the fee therefore itemized according to the schedule.

#75.40 Health Spas and Public Swimming Pools

The costs of using spas, public swimming pools or other exercise programs that are not provided by a recognized health care professional are not recognized by the Board as a health care benefit cost.

#76.00 HOSPITALS AND OTHER INSTITUTIONS

Only hospitalization that is directly necessary in the treatment of the worker's compensable injury may be paid by the Board.

#76.10 In-patient Treatment

In-patient per diem rates paid to hospitals are inclusive of all costs associated with the hospitalization. Costs associated with special nurses (see #75.20), beds or any other equipment are covered by the per diem rate and are not paid for separately.

The Board covers the cost of a public ward bed. However, a Board officer may authorize a private or semi-private bed where it is cost effective in minimizing wage loss resulting from a delayed admission.

A private or semi-private room will also be authorized where the critical condition of the claimant requires it.

#76.20 Short Stay Patients

Out-patient charges, including charges for emergency services, are covered by the Board where hospital services are necessary for the treatment. Where a physician chooses to see a patient in a hospital in lieu of an office visit, this is considered an arrangement between the doctor and the hospital. In such cases, only the doctor's physician services are paid for by the Board.

#76.30 Private Hospitals

Private hospitals may be utilized for treatment of pre-operative or post-operative patients who require active nursing care. The Board's approval must be obtained before a patient is admitted to such a hospital. If a patient is admitted without such approval, no payment will be made for hospitalization.

The attending physician must report to the Board at regular intervals regarding the patient's condition and the necessity for continued hospitalization.

The Board's approval must be obtained for any absence from the hospital for any purpose other than medical treatment and examination. No payments will be made for hospitalization during such a period of absence unless Board approval has been obtained. Any cases of intoxication, other substance abuse, or misconduct must be reported immediately to the attending physician and the Board.

#76.40 Laboratory Procedures

Board responsibility is limited to laboratory procedures required for diagnosis and treatment of conditions due to the compensable injury.

#76.50 Application of Compensation to Worker's Maintenance in Hospital

This is discussed in #49.10.

#77.00 DRUGS, APPLIANCES, AND OTHER SUPPLIES

In addition to medical examination and treatment, the Act provides for necessary health care benefits in the form of drugs, appliances, and other supplies.

#77.10 General Position

Accounts for medicine, bandages, and other supplies are payable only when they are prescribed by the attending physician and where medical reports to the Board verify their necessity.

Medicine, bandages and other items provided during an in-patient hospital stay are covered by the inclusive per diem rate. If, however, a claimant is provided an appliance or material for use after discharge, a separate charge is made by the hospital to the Board. This coverage is in lieu of the claimant being required to make the purchase from a medical supply house, such as a pharmacy, following discharge.

The Board may furnish appliances:

1. of a temporary nature to aid in the worker's recovery. The appliance is supplied as a temporary measure only and may not be replaced without the authorization of the Board;

2. of a permanent type when there is a permanent disability. Such an appliance is kept in repair and replaced as required.

Requests for repair or replacement of an appliance will usually be accepted without question when the repair or replacement is such as is reasonable to expect will result from normal wear and tear. This will normally be determined from the Board's experience as to the normal maintenance requirements and normal lifespan of the item in question. When a requested repair or replacement is not, on the face of it, such as is reasonable to expect from normal wear and

tear, investigation will be made as to the actual cause of the request. In general, this means that, on the one hand, responsibility will be accepted if the loss or damage is due to the wear and tear or an accident arising in the claimant's particular style of life. On the other hand, responsibility will be declined if the loss or damage resulted from deliberate or reckless abuse or has occurred with excessive frequency.

The repair and replacement of appliances broken or damaged at work is discussed in #23.00.

#77.20 Types of Supplies and Appliances

Set out below are some of the supplies and appliances provided by the Board and the conditions under which they are provided.

The list is not all inclusive. A claimant or the treating practitioner may contact the Health Care Benefits Department to determine if a particular item will be covered.

#77.21 Eyeglasses

Where eyeglasses are required because of an injury, the necessary corrective glasses are provided as required, as are artificial eyes. In all cases, hardened lenses are provided. Dark glasses may be supplied if prescribed by the attending physician or specialist as necessary. Frames are also supplied if damaged or not previously utilized.

Contact lenses may be provided at Board rates if the Board Medical Advisor considers they would improve the vision of, for example, an aphakic eye or scarred cornea.

Where an injury results in serious impairment to a worker's sight, the Board may, to protect remaining vision, provide protective eyeglasses. (15) Therefore, if a worker loses the sight or a substantial part of the sight of an eye in an industrial injury, glasses with hardened lenses are provided to protect the remaining sight.

The policy regarding repair or replacement is the same as outlined in #77.10.

#77.22 Hearing Aids

The provision of a hearing aid by the Board is not subject to any fixed monetary ceiling but is generally based on a negotiated fee schedule.

Where a claimant is adjudged entitled to health care benefits for loss of hearing, the Board will provide such hearing aid as is reasonable and necessary to achieve optimum satisfaction for the claimant.

The decision will be made by the Adjudicator generally after receiving medical advice and, if appropriate, input from an Occupational Hygiene Officer.

Where a claimant prefers a binaural hearing aid, this will be provided by the Board if it is expected to meet her or his needs, and it will be provided whether the preference is based on performance expectations or is purely aesthetic.

Claimants are advised not to make a private purchase of a hearing aid. Any such private purchase made will be at the claimant's own expense.

A telephone amplifier may be provided for hearing-loss claimants in cases where it is deemed appropriate.

#77.23 Artificial Limbs

Where an injury results in the loss of a hand, foot, arm, or leg, artificial limbs are supplied and kept in repair and replaced as needed. Wherever possible, prosthetic and orthotic supplies should only be requisitioned from facilities which have registered prosthetists and orthotists on their staff.

In all cases of major amputations, early referral to the Board's Rehabilitation Centre in Richmond is desirable (if there are no complications, as soon as the suture line has healed). A prosthesis will be supplied while at the Rehabilitation Centre, where ample time will be allowed for training in its use and for necessary adjustments while under observation.

Workers receiving artificial limbs are also entitled to the clothing allowance referred to in #79.00.

#77.24 Crutches, Canes, and Wheelchairs

Crutches or canes are covered where required as a result of the compensable condition.

Wheelchairs are issued to those claimants who are permanently disabled and unable to walk. A wheelchair may be replaced when no longer serviceable, but necessary repairs may be authorized periodically during the life of the chair.

#77.25 Boots and Shoes

Special footwear will be provided when:

1. there is a permanent deformity of the foot as a result of a compensable injury and standard footwear cannot be adequately adapted;

2. special footwear is required during rehabilitation or treatment for a temporary disability. This may include outside shoes required as a temporary measure.

Alterations to a worker's own boots and shoes, such as metatarsal bars, heel and sole raises, and arch supports, will be provided as a temporary measure, or on a permanent basis where necessary. The Board may request to examine footwear.

Where a claimant is receiving physiotherapy from a private clinic and it is necessary to purchase running shoes, the Board will reimburse the cost up to $25.00.

#77.26 *Belts and Braces*

Should the claimant's injury necessitate the wearing of a back belt, spinal or leg braces, splints or elastic stockings, these are supplied. This may be on one occasion only to enable the patient to overcome the effects of the injury, or in the case of permanent disability, it would be kept in repair and replaced as required.

The clothing allowance referred to in #79.00 is payable to workers who have to wear a leg brace.

#77.27 *Home and Vehicle Modifications*

With respect to major home and vehicle modifications required due to serious disabilities, the Vocational Rehabilitation Consultant investigates the need for these modifications. Where the renovations or modifications are for vocational purposes, they are considered as a rehabilitation expense. (See #90.00.) Where they are necessary for normal daily living because of the compensable medical condition, they are considered a health care benefit expense.

Examples of home modifications are ramps, elevators, wheel-in showers, grab-bars, doorway widening and wing taps for sinks.

Examples of vehicle modifications are hand controls and van lifts.

Necessary maintenance of the home or vehicle modification where required for medical purposes is also covered.

#77.28 *Medical Supplies for Paraplegics and Quadriplegics*

The Board supplies paraplegics and quadriplegics with all necessary medical supplies pertaining to their disability. These are obtained by contacting the Board's Health Care Benefits Department.

Where necessary, paraplegics and quadriplegics are provided with a range of medical equipment. Examples include hospital-type beds and mattresses, long leg braces, crutches, raised toilet seats, grab-bars, wheelchairs and commodes. The list includes the various items required to take care of bowel and bladder functions. Supplies also include condoms, tubing, darvol bags, suppositories and disposable gloves for example. Costs of water mattresses, waterbeds or alternating pressure pads are covered where needed to prevent skin breakdown or spasm.

#77.29 *Miscellaneous Items*

Generally, an item of equipment designed as a medical appliance (for example, a wheelchair) is acceptable as a health care benefit expense if it is medically required because of the compensable condition. Periodically, however, the Board receives requests to provide equipment not normally considered a medical appliance. Examples are hair-pieces, computers, televisions and specialized sports equipment. Unless the equipment is for the purpose of providing medical treatment for the compensable condition, or the individual is otherwise unable to carry out the normal functions of daily living and the equipment is designed for those reasons, it is not considered a health care benefit expense. In these circumstances, however, consideration may be given to providing such items as a rehabilitation expense.

#77.30 THE PRESCRIPTION OF NARCOTICS AND OTHER DRUGS OF ADDICTION

The following policy applies:

1. Board responsibility for narcotic analgesics, hypnotic-sedatives and tranquilizers (see examples in Table 1) will be limited to a post-injury or post-surgery period of eight weeks. An extension of this eight-week period may be considered, however, where there are special or extenuating circumstances; for example, where a worker has received, or will receive, a permanent disability pension and requires regular intermittent and limited narcotic preparation for the relief of pain.

2. If an Adjudicator or Payment Clerk continue to receive accounts for these drugs beyond the eight-week limit, the worker's claim will be referred by the Adjudicator to a Board Medical Advisor. The Board Medical Advisor will contact the attending physician by phone where possible, outline the details of this policy, and discuss any special or extenuating circumstances. The Board Medical Advisor will also discuss the use of acceptable therapeutic alternatives such as: N.S.A.I.D.'s, anti-depressives, T.N.S., biofeedback. If necessary, an

extension beyond eight weeks may be recommended by the Board Medical Advisor following this discussion.

3. The Board Medical Advisor's discussion and resulting recommendation will then be documented on the worker's claim file and referred to the Adjudicator.

4. The Adjudicator's decision will be communicated in writing to the worker with a copy to the attending physician.

Table 1

1. **Analgesic Target Drugs**

   (a) Analgesic combinations containing 50 mg or more of Codeine

   (b) Pentazocine and combinations (Talwin®, Talwin Compound 50®)

   (c) Oxycodone and combinations (Percodan®, Percocet®, etc.)

   (d) Propoxyphene and combinations (Darvon N®, 642®, 692®, etc.)

   (e) Merperidine (oral) (Demerol®)

   (f) Barbiturate + A.S.A. + Codeine combinations (Fiorinal®, Anadol®, Phenaphen®)

   (g) Anileridine (Leritine)

   (h) Morphine and M.S. Contin and M.O.S.

   (i) Hydromorphone (Dilaudid)

2. **Sedative-Hypnotic Drugs**

   (a) Barbiturates

   (b) Meprobamate

3. **Tranquilizers**

   (a) Diazepam

   (b) Chlordiazepoxide

EFFECTIVE DATE: October 1, 2007 – Revised to delete references to memos and memorandums.

APPLICATION: Applies on or after October 1, 2007

#78.00 DIRECTION, SUPERVISION, AND CONTROL OF HEALTH CARE

Health care furnished or provided shall at all times be subject to the direction, supervision, and control of the Board. (16)

It will be noticed that health care "is subject to" the direction, etc., not "under" the direction, etc. The Board has a choice, therefore, about the circumstances in which it will give direction.

#78.10 Direction, Supervision, and Control of Treatment

All questions as to the necessity, character, and sufficiency of health care to be furnished shall be determined by the Board. (17)

A main purpose of the control of treatment by the Board is to ensure that treatment is not overlooked, and that treatment choices are not overlooked. Much of the work takes the form not of "direction" or "control" but rather suggestions and advice to the attending physician. Insofar as the Board does exercise control, it relates largely to the approval or disapproval of payment for elective surgery. Sometimes, however, it may relate to other matters, such as a direction that the patient be examined by a specialist, or that a particular institution be attended rather than another.

The Board uses its control over treatment to promote recovery, and to exclude choices by patients or doctors that will delay recovery, or create an unwarranted risk of further injury. But the control of treatment by the Board is not intended to exclude patient choices. If there are reasonable choices of treatment, or reasonable differences of opinion among the medical profession with regard to the preferable treatment, or choices to be made that depend on personal preferences, the matter should be regarded as one of patient choice.

Where a treatment or appliance is deemed reasonably necessary and more than one type is suitable, the choice is left to the treating practitioner and the worker. Where, however, the selection of a treatment or appliance will likely result in a significant increase in the length of disability, the Board will normally authorize the treatment or appliance that is the most likely to enable the worker to return to work at an early date. If there is a substantial difference in costs of equally effective treatments or appliances, the Board will authorize the less costly. In such cases, if the worker chooses the more costly option, the Board will cover costs up to the amount that would have been paid for the less costly, but equally effective, option.

Where coverage for a non-standard treatment program, medical appliance or other health care benefit expense is contemplated, prior approval of the Board is

suggested. Either the health care professional or the worker may request this. Failure to do so may result in expenses being incurred that will not be covered by the Board.

Whether the treatment for a disability is an appropriate treatment for approval by the Board is a matter for decision by a Board Medical Advisor.

#78.11 *Authorization of Elective Surgery*

Authorization must be obtained from the Board before carrying out any elective procedures. Authority may be obtained by telephone, FAX, or letter. The Board does not expect the practitioner working under emergency conditions to obtain prior authorization before performing necessary procedures.

A particular surgical treatment will not be refused simply on the ground of a personal preference for an alternative course of action; but it will be refused if it is felt unduly hazardous, having regard to its potential benefits and the risks involved in not having the surgery, or unlikely to promote recovery, or totally unnecessary, or if it would seem reasonable to try less drastic measures first.

The conclusion of the Board Medical Advisor on an application for approval of elective surgery is not limited to approval or disapproval. It may include taking any other steps that the Board Medical Advisor considers would be sound medical practice. For example, if it should appear that the attending physician or the patient is expecting the operation to result in total recovery when it normally results in only limited improvement, the Board Medical Advisor may conclude that the operation should be approved, but that the matter should be discussed further with the treating doctor to try to ensure that the patient is informed of the likely results.

Where there is doubt about the existence of a disability, it is possible for the diagnosis of a Board Medical Advisor for treatment purposes to differ from the conclusions reached by the Claims Adjudicator for claims purposes. In other words, it is a legal and logical possibility for the Board to conclude that a claimant should be classified as a person having a particular disability for the purposes of compensation payments, but classified as a person not having that disability for the purposes of a particular remedial treatment. Suppose, for example, the claim is one for an internal disorder. Medical opinion is uncertain, but indicates about an equal probability that the claimant has this disorder. Applying the terms of Section 99 to the medical evidence, the correct conclusion, for claims adjudication purposes, may well be that the claimant has a disorder, and is entitled to compensation. But if the attending physician is seeking approval of a high risk operation, then, depending on the other variables, the Board Medical Advisor might decide that the surgery should be refused on the grounds that the probability that the claimant is suffering from that disorder is not sufficiently high to warrant the risks of that particular treatment.

In cases where authorization for treatment is not granted, the worker should be made aware of this decision in writing by the Adjudicator with a copy to the attending physician and specialist. The Claims Adjudicator must have this letter reviewed by the Medical Advisor to ensure the medical content is correct. An explanation of the decision should be given so that the worker can make informed decisions about the treatment or its relationship to the injury. The Board Medical Advisor will, except in rare circumstances, discuss this decision in advance with the treating physician or specialist.

If a worker acted reasonably in undergoing unauthorized treatment, compensation will be paid to him or her for the consequences of that treatment. The claim of the attending physician or specialist for payment of the cost of the treatment is, however, determinable by different criteria. The Board may not meet the cost of treatment after authorization for it has been refused. (18) This would depend largely on the degree to which the doctor was aware of the Board's position.

#*78.12 Worker Engages in Insanitary or Injurious Practices*

Section 57(2) provides in part that "The board may reduce or suspend compensation when the worker

(a) persists in insanitary or injurious practices which tend to imperil or retard his or her recovery; . . ."

The following principles are observed in applying this provision:

1. The worker must be made aware that the practice is deemed insanitary or injurious, that it must be discontinued, and that benefits will be reduced or suspended if she or he persists in the practice after that warning.

2. It will not be necessary in all cases for the Board officer imposing the suspension to do so only after securing medical advice to the effect that the practice is indeed insanitary or injurious. To take an extreme example, should an Adjudicator observe a claimant with a broken leg in a cast attempting to remove the cast because it is uncomfortable, it will be obvious to the Adjudicator, although a layperson, that the practice is not conducive to recovery and should be discontinued. On the other hand, in any situation where there is any room for doubt about the insanitary or injurious nature of the practice, it will be necessary for the Adjudicator to seek some medical advice before warning the claimant against a continuation of the practice.

3. Should the practice come to the attention of a Board Medical Advisor in the course of an examination, the claimant should be advised that the practice will retard recovery or tend to lead to further injury and

should be discontinued, and that the Adjudicator will be so advised of this opinion. It will then be the responsibility of the Adjudicator to formally advise the claimant that persisting in the practice will result in reduction or suspension of benefits.

4. Once benefits have been reduced or suspended, the claimant will be advised that an assurance, acceptable to the Adjudicator, that the insanitary or injurious practice will not be repeated, will be sufficient for resumption of full benefits. Of course, should the claimant persist in the practice after such assurance is given, benefits will once again be reduced or suspended forthwith and any further assurances will be received with considerable skepticism.

Section 57(2)(a) has no application where it is discovered after the fact that a claimant has engaged in an insanitary or injurious activity, but that activity has now ceased. The section is intended as an inducement by workers to take more care in promoting their own recovery and, therefore, is only applicable where the activity in question is continuing. However, compensation may be denied without invoking this section if the insanitary or injurious conduct engaged in by a claimant shows that the claimant was not disabled during the period in question, or if the evidence indicates that the disability was due to this conduct rather than to the original work injury.

#*78.13 Worker Refuses to Submit to Medical Treatment*

A claimant will not be forced to accept treatment the claimant does not wish to receive nor treatment from a doctor against whom he or she has objection.

However, Section 57(2) provides that "The board may reduce or suspend compensation when the worker

(a) . . .
(b) refuses to submit to medical or surgical treatment which the board considers, based on expert medical or surgical advice, is reasonably essential to promote his or her recovery."

The term "medical treatment" in this subsection is not limited to treatment performed by doctors. It includes, for example, therapy by paramedical personnel.

Decisions on whether compensation should be reduced or suspended under this subsection are made by the Adjudicator; but there must be an input of medical advice. Where a Rehabilitation Consultant is working on the case, he or she must also be consulted.

Under Subsection 2(b), there must be a clear medical opinion on file that the relevant treatment "is reasonably essential to promote his recovery". There must

be evidence that the worker has been offered that treatment and knows that it is considered by the Board reasonably essential to promote recovery. There must be evidence that the worker was in a position to make a choice, and refused the treatment. Also, the worker must be given a chance to explain before any decision is made.

Subsection 2(b) is not intended to exclude all patient choices, and even when the terms of the subsection are satisfied, the Adjudicator is not bound to reduce or suspend compensation benefits in every case. There is a discretion. For example, if the proposed treatment involves a significant risk of an adverse side-effect, or a questionable prospect of success, or is hazardous, the Adjudicator might well conclude that the refusal to undertake that treatment was reasonable.

#*78.14 Acupuncture*

The Board does not generally accept responsibility for acupuncture. Any exception must be previously authorized. Even where an exception is allowed it is usually only for a short period of time and then only in conjunction with an overall program for dealing permanently with the claimant's problem such as is found at a pain clinic. The Board would not likely authorize the treatment where it was being carried out on a routine long-term basis. Where approval of acupuncture treatment is granted, the number of treatments allowed and the fees payable will be set. Requests for authorization of acupuncture treatment are initially referred by the Adjudicator to the Unit or Area Office Medical Advisor. Where this Board doctor feels that treatment approval should be considered, the claim is referred to the Vice-President, Medical Services Division for a decision. The request should provide details such as the number of treatments, the cost and the expected benefits. Treatments that do not meet the above general criteria are usually denied at the unit or area office level.

#78.20 Examinations and Consultations

Section 57(1) provides as follows:

> "The board may require a worker who applies for or is in receipt of compensation . . . to be medically examined at a place reasonably convenient for the worker. If the worker fails to attend for the examination or obstructs the medical examiner, the worker's right to compensation is suspended until the examination has taken place, and no compensation is payable during the period of suspension."

The examination may be by the worker's own attending physician, a Board Medical Advisor/Consultant or an outside consultant. The worker will be notified in advance of the type of doctor or practitioner who will do the examination.

#78.21 *Examination at the Board*

A Board Medical Advisor does not arrange to examine a worker on his or her own initiative. If a request is received from an attending physician the Adjudicator is consulted before an examination is arranged.

In all cases, the attending physician will be notified by letter of the intention to bring the worker to the Board for an examination (or consultation with a specialist).

The attending physician will be notified by the Adjudicator of any claims decision following the examination, and any changes in the status of the claim, unless matters of internal administration only are involved. The Board Medical Advisor is responsible for notifying the attending physician of any medical matters that should be brought to the physician's attention following the examination.

#78.22 *Consultation with Specialists*

In an accepted claim where treatment is continuing and no transportation costs for the worker are involved, no permission of the Board for a consultation is necessary. No consultation shall be charged to the Board unless the necessity for consultation in respect of the injured part has been shown on the referring doctor's reports.

Where transportation costs for the worker are involved, permission for the referral of a worker for consultation must be obtained from the Board.

Where the Board arranges a consultation with a specialist, the attending physician must be notified of the appointment. Where a Board Medical Advisor wishes to refer a worker to a consultant, it will, if practicable, first be discussed with the attending physician giving him or her an opportunity to express a preference as to the consultant.

When a consultation is authorized on an investigative basis for an opinion necessary for the adjudication or possible reopening of a claim, arrangements may be made for the examination of the worker at the Board prior to being seen by the specialist. This is at the discretion of the Board Medical Advisor. Where the validity of the claim has not yet been determined, it will be indicated to the specialist that no treatment or compensation benefits can be authorized until the decision has been made on the claim.

Board policy does not permit approval of surgery on an investigative basis. Investigative referrals for consultation or examination do not extend to invasive procedures that could result in a disability. Where surgery is being requested, and it is not felt the condition is a Board responsibility, the worker is advised that such surgery must be undertaken on a private-patient basis. The worker is also

advised that the Board will be prepared to review the surgical report to determine whether any Board responsibility does exist.

When the opinion of a consultant is being sought, the Adjudicator and the Board Medical Advisor are required to detail exactly the relevant medical questions which must be specifically addressed by the consultant. The instructions to the consultant are in writing.

When a worker has been referred to a specialist at the request of the attending physician with reference to diagnosis or treatment, a copy of the specialist's report will be sent to the attending physician by the specialist or the Board Medical Advisor. Similarly, when the worker is referred by a Board Medical Advisor to a specialist with reference to diagnosis or treatment, a copy of the specialist's report will be sent to the attending physician.

Decisions taken with regard to appropriate action upon receipt of the consultant's report will be the responsibility of the Board Medical Advisor with respect to treatment issues, and the responsibility of the Adjudicator with respect to adjudication issues.

#*78.23 Psychiatric Treatment and Consultation*

Where a psychiatric examination is being arranged, it will, in most cases, be on an investigative basis. Psychiatric treatment will not normally be authorized until a report has been received from the psychiatrist relating to diagnosis, etiology, treatment possibilities and prognosis.

#*78.24 Failure to Attend, or Obstruction of, Examination*

Before compensation can be suspended under Section 57(1) on the grounds of a failure to attend, or obstruction of, a medical examination, the following prerequisites must be satisfied:

1. There must be clear evidence that an appointment was made and that the date, time and place were communicated to the worker and that the worker did not advise, by letter or otherwise, that the arrangements for the examination were not convenient.

2. There must be clear evidence of obstruction.

3. The worker must be advised by the physician, in general terms, of the provisions of Section 57 and that the obstructive behaviour will be reported to the Adjudicator.

4. Should the worker persist in refusing to be examined or in obstructing the examination, the attempt shall be concluded and the matter referred forthwith to the Adjudicator.

5. The Adjudicator must advise the worker, in person, by telephone, or in writing, of the intention to apply Section 57(1), reasons for the intended action, and the worker must be given an opportunity to explain the refusal or obstruction.

6. Should an explanation not be forthcoming, or should it be deemed unsatisfactory by the Adjudicator, payment of benefits shall be suspended.

7. Should the worker not appear for the examination, the steps outlined in (5) and (6) above shall be undertaken.

8. Notice to the claimant of the suspension of benefits shall include notice of an appointment for a further examination and should advise that, should the worker attend and be examined on that occasion, benefits will be reinstated, however, without retroactivity.

Where a pension is instituted, the retroactive date of the pension should not automatically be the day following the date of wage-loss suspension. The effective date of the pension must be the date when it is deemed the worker's condition has stabilized.

#78.30 Fees or Remuneration

The Board may contract with physicians, nurses, or other persons authorized to treat human ailments, hospitals, and other institutions for any health care required, and to agree on a scale of fees or remuneration for that health care. (19)

The fees of health care professionals are normally governed by fee schedules approved by the Board. These may be fees negotiated specifically by the Board or the Board may have decided to adopt the fee schedule of another agency such as the Medical Services Commission. Where there is not an approved fee schedule, the treatment and the fees payable must be approved in advance by the Board.

The fees or remuneration for health care furnished shall not be more than would be properly and reasonably charged the worker if personally paying, and the amount shall be fixed and determined by the Board, and no action for an amount larger than that fixed by the Board shall lie in respect of health care benefits. (20) The doctor is not permitted to bill the worker for any balance of the account regarding a compensable condition which the Board has not agreed to pay. If

the doctor does this, the Board reimburses the claimant, but deducts the amount from any future account the doctor submits to the Board.

Information regarding the current fee schedules of the Board for the professions and other suppliers of goods and services can be obtained by applying to the Board.

#78.31 *Adjudication of Health Care Benefits Accounts*

All accounts submitted to the Board for services and goods provided for injured workers are audited by the Health Care Benefits Department of the Board to ensure compliance with the Act and the fee schedules, and to ensure that the services or goods are appropriate to the worker's condition.

Where it is determined that services or goods supplied to a claimant are not related to a compensable condition, the supplier will be notified as soon as possible.

When a decision is made by a Board officer that a worker's ongoing problems are not considered compensable, this decision is conveyed in writing to all concerned, including individuals or facilities that submit treatment accounts. Regardless of the timing of the decision letter and the receipt of accounts, no accounts are payable for treatments after the date the worker is no longer deemed to be suffering from a compensable condition.

For a variety of reasons, the Board may decide to limit medical treatment even though the worker's ongoing complaints are considered to be compensable; for example, a denial of concurrent treatment (#74.60) or a denial of an extension of chiropractic treatment (#74.21) or physiotherapy (#75.12). When such limitations occur, the Board normally will pay accounts up to the date of the decision letter if the reports or accounts are submitted promptly and in good faith. If the practitioner, however, neglects to inform the Board of the treatment until some time after it is provided and by so doing delays the Board's decision, these accounts will not be paid.

All accounts should be submitted promptly at the conclusion of the transaction or treatment. Section 56(3) provides that "Unless the board otherwise directs, an account for medical services or health care must not be paid if it is submitted later than 90 days from the date that

(a) the last treatment was given; or
(b) the physician or person furnishing the medical service was first aware that the board may be liable for his or her services, whichever first occurs."

In applying this section, some degree of discretion is exercised. The general policy is that if a person has provided a medical service it should be paid for.

However, serious offenders may be notified of this requirement. If they continue their practice of late billing, their accounts may be rejected.

#78.32 Reversal of Decision on Review or Appeal

Where a claim, previously allowed, has now been disallowed, the Board will not initiate any steps to recover health care benefit payments already made; but if the Board is offered reimbursement by any other agency, the offer will be accepted.

Where accounts are outstanding at the time when the disallow decision is made, or are received after the decision, those accounts will not be paid, and the people rendering the accounts will be advised to submit them elsewhere. In these circumstances, the Board only declines to pay accounts for treatment, etc. Fees for reporting to the Board are still payable; so are the fees for any examination of the patient undertaken at the request of the Board for adjudication purposes.

Where a claim, previously disallowed, is now allowed, the Board will not at its own initiative solicit accounts for health care rendered prior to the date when the claim is allowed; but if accounts are received in respect of health care already rendered in respect of the compensable injury, and the Review Division or the Workers' Compensation Appeal Tribunal decision does not deal with the question of entitlement to that health care, the accounts are adjudicated as if the claim had been accepted in the first instance. The Board officer has, however, a discretion to pay for medical treatment or procedures undergone by the worker in good faith on the advice of his or her practitioner, even though the treatment or procedures might not ordinarily be approved for the worker's condition. The Board will not, under this policy, pay for treatment modalities or diagnostic procedures not generally recognized by the Board.

A copy of the Review Division or Workers' Compensation Appeal Tribunal decision reversing the previous decision is sent to the attending physician.

EFFECTIVE DATE: March 3, 2003 (as to references to the Review Division and The Workers' Compensation Appeal Tribunal)
APPLICATION: Not applicable.

#78.33 Form Fees

Where a claim is disallowed or suspended, and accounts submitted for treatment are not being paid, a form fee is paid in respect to any medical reports submitted prior to the date of the decision to disallow or suspend the claim.
Where a claim is rejected, that is, where:

1. a self-employed worker has no personal optional protection; or

2. the claimant was employed by an employer not covered under the Act; or

3. a report was submitted in error;

form fees are not normally payable. In the event of the unusual situation where a medical report had been requested by the Board and the claim is eventually rejected, the form fee will be paid.

#79.00 CLOTHING ALLOWANCES

The clothing allowances set out below are payable to upper and lower limb amputees wearing prostheses, and to workers wearing a leg brace. (21) The amputation must be at or above the wrist, or at or above the ankle. Effective July 1, 1993, the allowance is also payable to a worker confined to a wheelchair, who is not otherwise entitled, at the same rate as is payable to a lower limb amputee.

	Single Upper Limb Amputee	**Bilateral Upper Limb Amputee**	**Lower Limb Amputee or Requires a Leg Brace**	**Upper and Lower Limb Amputee**
July 1, 1998 - June 30, 1999	$236.89	$474.93	$474.93	$711.88
July 1, 1999 - June 30, 2000	240.83	482.82	482.82	723.71
July 1, 2000 - June 30, 2001	245.86	492.91	492.91	738.83
July 1, 2001 - June 30, 2002	254.61	510.45	510.45	765.12

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

Effective January 1, 2008, the amounts of the clothing allowances will be adjusted on January 1 of each year. The Board determines the percentage change to be applied annually to these amounts by comparing the percentage change in the consumer price index for October of the previous year with the consumer price index for October of the year prior to the previous year.

Payment of the allowance is automatically made by virtue of the amputation. Proof is required neither of the wearing of the prosthesis or prostheses nor of the replacement, repair, or damage to clothing. Payment in the case of leg braces is contingent on the continued wearing of the apparatus.

Entitlement to this allowance commences as of the date of the amputation or the worker's commencing to use the brace or wheelchair. Payment is made by separate cheque on January 1st of each year. This is a full calendar year payment which covers the year of payment. The first payment is made on the January 1st following the initiation of pension payments and this first payment will include any retroactive entitlement for prior periods of disability not previously paid.

Payment of this clothing allowance is withheld while a worker is in prison. The amount withheld is paid to the worker on release if the period in prison was less than one year. If the period in prison is more than one year, the clothing allowance is not paid for each full year the worker was in prison.

EFFECTIVE DATE: October 1, 2007 – Revised to change the reference to the date of clothing allowance adjustments from July to January 1st of each year.

APPLICATION: Applies on or after October 1, 2007

#80.00 PERSONAL CARE EXPENSES OR ALLOWANCES

In cases of major injuries, such as spinal cord injuries, resulting in paraplegia or quadriplegia, severe head injuries, hemiplegia, aphasia, near or total blindness, multiple amputations, or severe disability as a result of occupational diseases, the Board may pay certain personal care expenses. These expenses are in addition to wage-loss or pension benefits.

Personal care expenses may be paid when a seriously disabled person, though not confined to an institution, has very limited mobility or requires assistance in toilet functions, bathing, eating, or has other problems in caring for himself or herself, or needs assistance to a lesser or greater degree in daily living. Personal care expenses are payable at the discretion of the Board. An investigation is made of the circumstances of each case.

While aimed primarily at situations where there is severe permanent disability, in limited situations personal care expenses may also be paid in cases of severe temporary disability. Before making temporary payments, consideration is given to such factors as the worker's home and family situation, geographical location, the medical condition and other relevant difficulties.

In lieu of the actual personal care expenses incurred by the worker, the Board may pay a flat rate personal care allowance determined in accordance with the principles set out in #80.10 and #80.20 below.

The payment of personal care expenses or allowances will cease upon the death of the worker.

#80.10 Levels of Personal Care Allowances

There are five levels of personal care allowances:

Level 1: The claimant has restricted mobility but can feed, partly cleanse and otherwise care for himself or herself but does need some assistance in acts of daily living.

Examples are:

Blindness or near blindness, multiple amputations at or above the wrist or ankle, aphasia, hemiplegia, or any permanent disability resulting in a loss of function of the limbs, but not to an extent that significantly impairs other body functions.

Level 2: Restricted mobility. Claimant can feed, clothe and wash himself or herself but needs assistance in other aspects of personal care and acts of daily living.

This includes:

Paraplegia with bowel and bladder functions impaired.

Level 3: Restricted mobility. Claimant needs ongoing assistance in washing, shaving, dressing, feeding, precautionary attention to skin care and ongoing assistance in daily living.

Examples are:

1. Severe head injury resulting in brain damage to the extent that the claimant is not bedridden, but is dependent upon assistance and ongoing care.
2. Quadriplegia with impairment of bowel and bladder functions.

Level 4: Claimant is almost totally immobile and requires extensive assistance in maintaining personal hygiene, precautionary attention to skin care and ongoing assistance in all phases of daily living.

Examples are:

High lesion quadriplegia or severe head injuries.

Level 5: The claimant is totally immobile for all practical purposes and essentially requires assistance in all phases of personal hygiene, body functions and acts of daily living (quadriplegic, decerebrate and bedridden).

The determination of whether a personal care allowance is applicable and the appropriate level may include consideration of factors such as home and family situation, geographic location and other difficulties that may be encountered in relating to the claimant's environment. Other medical conditions that may not be a direct result of the personal injury sustained may also be considered in the determination.

Personal care allowances may be adjusted up or down in the event that the circumstances following the original application substantially change.

#80.20 Amounts Payable at Each Level

The amounts of personal care allowances are set out below.

	Level 1	Level 2	Level 3	Level 4	Level 5
January 1, 1999–December 31, 1999					
Daily Amount	12.38	21.09	31.37	40.62	50.09
Monthly Amount	372.64	651.96	941.68	1,221.00	1,500.62
January 1, 2000–December 31, 2000					
Daily Amount	12.66	21.57	32.09	41.55	51.24
Monthly Amount	381.19	666.91	963.27	1,249.00	1,535.03
January 1, 2001–December 31, 2001					
Daily Amount	13.01	22.17	32.98	42.71	52.66
Monthly Amount	391.79	685.45	990.06	1,283.72	1,577.71
January 1, 2002–December 31, 2002					
Daily Amount	13.26	22.60	33.62	43.53	53.67
Monthly Amount	399.31	698.61	1,009.07	1,308.36	1,608.00

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

After January 1, 1993, the amounts of the personal care allowances 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).

#80.30 Payment Procedure

Where the Board is paying the worker's actual expenses, it may pay directly the account of a company registered to provide the required assistance. The Board does not pay a personal care allowance directly to an individual attendant.

In a case where the worker is receiving a flat rate allowance or has hired an individual attendant, the amount is paid directly to the worker if he or she is capable of money management.

Once approved, personal care allowances are normally paid monthly. The worker, or the person providing the care, is required to complete and sign the prescribed form and return it to the Board each month, or at such other intervals as may be determined by the Board.

#80.40 Claimant Requires Institutional Care

The payment of personal care expenses or allowances will be suspended if the claimant is institutionalized for more than fourteen calendar days, but may be reinstated upon returning home.

If a claimant is totally disabled and requires ongoing institutional care as a result, a flat rate personal care allowance will not be paid. The Board provides the cost of institutional care as part of the health care benefit program. If it appears that such a claimant can be provided the same kind of nursing or custodial care outside an institution, the Board may, as an alternative to paying personal care allowance, pay an amount calculated, at least in part, by reference to the cost of institutional care.

#81.00 INDEPENDENCE AND HOME MAINTENANCE ALLOWANCE

Normally, most workers who are homeowners have the physical capacity to maintain their property in order to protect their investment in home and property. Such things as painting, repairing, landscaping, appliance repairs, renovations and the many other activities required to maintain the home are difficult or impossible for the disabled. The severely disabled claimant is usually required to hire tradespersons or others to carry out these activities, thereby incurring additional costs for maintaining home and property.

Similarly, the disabled claimant may not have the physical capacity to maintain and/or drive a car or to use public transportation, and is consequently required to hire taxis or other forms of transportation to enjoy a reasonable degree of independence.

In order to assist in these and similar kinds of expenses, the Board has established a category of assistance separate and distinct from personal care allowances, called the independence and home maintenance allowance. This allowance may be paid over and above any level of personal care allowance and is in addition to any wage-loss or pension benefits.

Effective September 1, 1992, the criteria for paying the independence and home maintenance allowance are as follows:

1. The worker must have sustained a permanent compensable disability which meets one of the following criteria:

   (a) The disability measured using the physical-impairment method of assessment is equal to 75% of total or greater.

   (b) The disability measured using the projected-loss-of-earnings method of assessment is equal to an equivalent of 75% of total or greater and it is concluded, after obtaining the advice of the Vocational Rehabilitation Consultant, that the disability will prevent the worker from carrying out the activities covered by the allowance.

   (c) The compensable disability is superimposed on another permanently disabling medical condition, whether compensable or not, and the combined disability meets (a) above or the Board grants a projected-loss-of-earnings award which meets (b) above. Where the pre-existing disability is non-compensable, the compensable disability must be at least half the combined disability measured using the physical-impairment method of assessment and be a significant factor in the worker's inability to do the activities covered by the allowance.

2. The worker must maintain a home or live in rented accommodation. A worker who lives in a nursing hospital or extended care facility will not be eligible. Other accommodation may be approved if it can be concluded that the worker would have contributed to its maintenance had the disability not occurred.

3. If the worker is institutionalized in a hospital, nursing care facility or extended care facility, but the spouse and children continue to maintain the family home, the allowance may be paid to the spouse.

4. The allowance commences as of the date when the worker meets the criteria set out above and will be terminated upon the death of the worker or if the worker ceases to meet the above criteria. The allowance may be paid retroactively if time elapses between the date of the worker becoming eligible for the allowance and the date eligibility is determined. With regard to any period prior to September 1, 1992, no payment can be made unless the worker meets the criteria which existed prior to that date. (22)

The independence and home maintenance allowance is payable at the discretion of the Board. The circumstances surrounding each case will be reviewed by the Rehabilitation Consultant who will provide a report and recommendations.

Once the allowance is approved, the worker or spouse is required to complete and sign the appropriate form and submit it each month, or at such other intervals as may be determined by the Board.

The amount of the independence and home maintenance allowance is set out below.

Date	Monthly Amount
January 1, 1999 – December 31, 1999	$196.99
January 1, 2000 – December 31, 2000	201.51
January 1, 2001 – December 31, 2001	207.12
January 1, 2002 – December 31, 2002	211.09

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

After January 1, 1993, the amount of the independence and home maintenance allowance 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 independence and home maintenance allowance is not retroactive to before June 13, 1980, but, subject to the claimant's qualifying as above described, the allowance is paid regardless of date of injury or permanent disability due to occupational disease.

#82.00 TRANSPORTATION ALLOWANCES

Section 21(1) authorizes the Board to furnish or provide the injured worker with transportation it may deem reasonably necessary.

#82.10 Eligibility for Transportation

Subject to the exceptions set out at the end of this item, return transportation expenses are normally reimbursed when:

1. A worker travels to a place of medical examination or treatment where the appointment has been previously approved by the Board or is subsequently paid for by the Board; or

2. A worker travels in connection with a vocational rehabilitation program where the travel is requested or approved as part of the program by the Vocational Rehabilitation Consultant; or

3. A worker is at the time of injury working at a place other than his or her place of residence and wishes to transfer to the place of residence and the disability from the injury prevents the worker from using the mode of transportation which he or she ordinarily would have used to do this; or

4. A worker meets the criteria set out in policy items #100.12 or #100.13 in connection with attendance at a claims or Review Division inquiry.

Transportation expenses are not normally paid in regard to:

1. Travel within the boundaries of a local bus service (including the area serviced by the Greater Vancouver Regional District transportation system) where the bus is a reasonable means of transportation for the worker.

2. The portion of any journey which takes place within a distance of 24 kilometres of the destination. This does not apply where the worker's condition is such as to require travel by:

   (a) ambulance; or

   (b) taxi, and the worker has received prior authorization for this from the Board.

3. The portion of any journey which takes place beyond the boundary of the province. This does not apply where the Board specifically requests the claimant to attend a medical examination, or in certain situations specified in policy item #100.15 in relation to claims or Review Division inquiries.

The Board may be ordered by the Workers' Compensation Appeal Tribunal to pay certain expenses. Section 7 of the *Workers Compensation Act Appeal Regulation* (B.C. Reg. 321/2002) provides that the Board may be ordered by the Workers' Compensation Appeal Tribunal to reimburse a party to an appeal under Part 4 of the *Act* for the following kinds of expenses:

- expenses associated with attending an oral hearing or otherwise participating in a proceeding, if the party is required by the Workers' Compensation Appeal Tribunal to travel to the hearing or other proceeding; and

- expenses associated with obtaining or producing evidence submitted to the Workers' Compensation Appeal Tribunal; and

- expenses associated with attending an examination required under section 249(8) of the *Act*.

However, the Workers' Compensation Appeal Tribunal may not order the Board to reimburse a party's expenses where those expenses arise from a person representing

the party or the attendance of a representative of the party at a hearing or other proceeding related to the appeal.

EFFECTIVE DATE: March 3, 2003 (as to references to the Review Division, the Workers' Compensation Appeal Tribunal and section 7 of the *Workers Compensation Act Appeal Regulation*)

APPLICATION: Not applicable.

#82.11 Worker Bypasses Nearby Medical Facilities

Claimants may, of their own accord, bypass adequate local treatment facilities to attend a practitioner of their own choice elsewhere. The *Workers Compensation Act* allows freedom of choice of physician or qualified practitioner by the injured worker. Obviously, there must be some limitation of the costs of such freedom. For example, a worker in Prince George could not reasonably insist that since the physician or qualified practitioner of her or his choice worked in Vancouver, there should, therefore, be reimbursement for transportation to and from Vancouver to seek this medical care.

If, however, necessary medical care is only available in a given centre, or the Board, acting on the advice of the health professional, refers a worker to another centre for medical care, the costs of transportation will be chargeable to the Accident Fund.

If a worker, by choice, bypasses adequate local treatment facilities, transportation costs will not be paid. Adequate treatment facilities in this case are defined as physicians or hospitals in all cases. Since all other "qualified practitioners" are limited in the types and extent of care they can offer, it would not be reasonable to prohibit a worker from bypassing one of those practitioners to get to the nearest hospital or doctor. On the other hand, it would be unreasonable to allow a worker to bypass a hospital or a doctor to go to a "qualified practitioner". (23)

A worker may, following the injury, move his or her place of residence to another location and thereby incur increased transportation costs. This may or may not be because the worker was injured while working away from home. The Board will not normally pay the cost of the move from one place of residence to another. It will, however, pay normal transportation costs for travel from the place where the worker resides to a place of treatment or examination in the worker's area of residence even though the worker's choice of place of residence results in greater transportation costs. The Board will not pay for travel from the place of residence to a doctor in the worker's former residence unless the worker's condition requires treatment by that particular doctor.

#82.20 Amount of Reimbursement

The principles set out below apply with regard to expenses incurred in connection with a claim or Review Division inquiry.

The Board will pay the cost of public transportation where this is available and is a reasonable and normal means of travel for the journey to be made by the worker. Where the Board consider it advisable, a worker will be encouraged to travel by air and the Board will assume the cost of the air fare, together with the cost of transportation to and from airports. In situations where air travel is acceptable and the worker elects to use some alternative means, such as the use of a private car, only the most reasonable and economical public transportation cost, which is usually the bus fare, will be reimbursed. Where air travel is not practical, and not approved, only the bus fare will normally be reimbursed irrespective of the method of travel utilized by the worker. The "bus fare" rate includes necessary meal costs and taxi costs to and from bus terminals.

Where public transportation is not reasonably available, the most economical method of transport that is reasonably available will be considered.

Taxi fares will be paid when medical reports indicate that the worker's condition does not permit travel by public transportation. The worker must first obtain prior Board approval and will be required, if no voucher is provided, to obtain receipts from the taxi driver and submit the receipts for a refund.

Where there is no public transportation available, or it is deemed otherwise reasonable and acceptable for the worker to drive his or her own vehicle, an allowance of 28 cents per kilometre is paid, effective January 1, 1997, for journeys meeting the minimum kilometre limit set out in #82.10. Prior to January 1, 1997, the allowance was paid as follows:

Date	Amount Per Kilometre
January 1, 1999 - December 31, 1999	28¢
January 1, 2000 - December 31, 2000	29¢
January 1, 2001 - December 31, 2001	30¢
January 1, 2002 - December 31, 2002	30¢

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

It may, for example, be considered reasonable for a worker to drive his or her own vehicle where there is available public transport if the bus journey would involve multi bus transfers or coming by automobile would be acceptable where it permits the worker to put in half a day at work and still keep an appointment. Parking fees are payable if parking charges are levied by the hospital or medical building where the worker is attending for treatment, but are only paid where approval has been given to pay a kilometre allowance.

After January 1, 1993, the kilometre rate will be adjusted on January 1 of each year. The Consumer Price Index ratio determined under section 25 of the *Act* for January 1

and the previous July 1 will be used (see policy item #51.00). The result is rounded to the nearest cent.

Where a worker has voluntarily moved out of the province, eligible expenses are normally limited to what would be paid if the expenses were incurred in British Columbia. Where travel costs are being paid, the cost of travel back to British Columbia (usually the air fare) is prorated on a kilometre basis and the payment covers only the percentage of the travel occurring in British Columbia.

Parking fees may be payable where approval has been given to pay a kilometre/mileage allowance.

Where a worker has to buy meals while engaged in a journey for which the Board is paying expenses, the Board will pay the rates set out in policy item #83.20.

Flat rate travel allowances to cover the cost of different forms of transportation from different starting points to different destinations may be established. This includes situations where part of the journey takes place outside the province. These allowances should cover the normal cost of the journey in question including incidental costs such as parking, taxi, airporters, and meals which will usually be incurred in the journey. The amount of the allowance may be paid to the worker in place of actual expenses.

The worker in receipt of a flat rate payment may request reimbursement of actual expenses if, because of exceptional circumstances, expenses are incurred which are significantly higher than the amount of the flat rate. These expenses would have to meet the normal criteria for payment set out in this part of the manual.

EFFECTIVE DATE: March 3, 2003 (as to reference to the Review Division)
APPLICATION: Not applicable.

#82.30 Manner of Payment

Air travel is normally arranged through a travel agency used by the Board.

Travel arrangements may also be made by forwarding a cheque to the worker in advance of the scheduled trip. Normally, such advance payments will only be paid at the rate of the bus fare. In any exceptional situation where the cheque forwarded to the worker is to cover an air fare, but the worker elects to use other transportation that is less expensive, the Board will not ask for a refund of the difference in cost.

Where an advance payment has been made and the worker does not keep her or his appointment and another appointment cannot be arranged, the worker will be asked to return any transportation expenses that have been advanced. They will be treated as an overpayment. (24)

#82.40 Transportation Provided by the Employer

Every employer shall, at its own expense, furnish to a worker injured in its employment, when necessary, immediate conveyance and transportation to a hospital, physician or qualified practitioner for initial treatment. (25) After such initial treatment, the Board provides any necessary transportation.

In the event a doctor is called to the scene of the accident, the employer shall be responsible for any charge made by the doctor with respect to mileage or travelling time. Where air transportation is utilized, stretchers suitable for use in planes shall be provided.

The transportation of an injured fisher to a hospital or physician or qualified practitioner is discussed in Fishing Industry Regulation 13 (found in Workers' Compensation Reporter Decision 223).

#82.50 Flight Changes

Because of advance bookings, flight reservations made by the Board are normally at a preferred rate.

A worker may change a flight reservation or elect to fly after having previously advised that he or she will use some other means of transportation. This may result in increased flight cost. The Adjudicator will investigate the reasons for the change. If the investigation establishes that the change was necessitated for some emergency or other unavoidable reason, the Board will pay the costs incurred. If, however, it is shown that the change was due to a personal choice or preference on the part of the worker, the worker will either not be entitled to reimbursement of the additional costs incurred or may be required to reimburse that amount to the Board. The latter may be accomplished through a deduction from future wage-loss entitlements.

Claimants scheduled to travel by air are advised in advance of this policy.

#83.00 SUBSISTENCE ALLOWANCES

The Board may make a daily allowance to an injured worker for subsistence when, under its direction, the worker is undergoing treatment at a place other than the place of residence. The power of the Board to make a daily allowance for subsistence extends to an injured worker who receives compensation, regardless of the date of first becoming entitled to compensation. (26)

#83.10 Eligibility for Subsistence

Subsistence may be paid where a journey, for which the Board is paying transportation expenses (see #82.10), requires the worker to spend one or more nights away from home. It may continue to be paid for the duration of a treatment or vocational rehabilitation program which has been approved by the Board, and which requires the worker to spend a period of time away from home.

In determining whether a journey or program requires a worker to stay from home overnight, regard will be had to whether the worker can travel from home and return daily for a cost less than the amount that would be paid for subsistence.

Unless maintaining a connection to a place other than where the Board has directed the worker to be, no subsistence payments will be made. Maintaining a connection means paying a significant amount of rent, mortgage, or other fee or cost that guarantees a place for the worker to live upon return.

Where a worker is maintaining a residence close to work and also has a residence in another place, subsistence will not be paid while receiving treatment in either place. This is so even though the employer provides an allowance to cover the cost of the residence close to the work place and this ceases while the worker is disabled. However, the amount of the allowance is treated as part of the worker's earnings for the purpose of computing wage-loss benefits. (27)

No subsistence is payable where a worker receives accommodation at the Board's Rehabilitation Residence. This is so even though the worker elects to visit home or leave the Residence for some other purpose at a weekend. The Board will provide Residence accommodation to workers eligible for admission (28) who are not maintaining a connection to a place but who have been directed to travel to Richmond by the Board. In these cases, there will be no subsistence paid in lieu of Residence privileges.

Residence accommodation or subsistence is not available to workers who, at their own choice, simply choose to travel to Vancouver or any other centre for treatment or to await recovery.

#83.11 Travelling Companions

The following general rules will apply with regard to subsistence payments and Residence accommodation for travelling companions, attendants or visitors for injured workers. Reimbursement of costs for persons other than the worker does not include any wage or income loss incurred.

1. Where it is medically necessary, the Claims Adjudicator will authorize subsistence payments or Rehabilitation Residence accommodation for one night for a travelling companion to take a patient to a treatment centre, medical examination or meeting in any city where it is not reasonable to expect the travelling companion to return home that day. Another night may be allowed to accompany the patient home if he or she is required to stay more than one day at that centre and a travelling companion is medically necessary in the opinion of the Adjudicator. (In case of emergency, other designated Board officers may authorize travel and subsistence.) Where it is not necessary for the travelling companion to stay overnight, travel costs and appropriate meal allowances will be paid.

2. Where an injured worker is in critical condition in a hospital, a spouse, relative or other person from the worker's residence with a close attachment to the injured worker may receive transportation costs, subsistence payments or Residence accommodation as long as the worker remains in critical condition.

3. Where an injured worker has sustained a major amputation and the presence of a spouse or parent is deemed advisable, the spouse or parent may receive transportation costs, subsistence payments or residence accommodation to visit with the injured worker, during the early stages of treatment and the fitting of a prosthesis in the Rehabilitation Centre.

   Approval for these visits is recorded on the claim and requires approval from the Amputee Group Physician and the Manager of the Rehabilitation Centre[1] or their delegates.

4. Where under Board sponsorship or direction a worker is undergoing a period of treatment or retraining which requires the worker to live elsewhere than her or his normal residence for a period of six weeks or more, the Adjudicator will, on not more than one occasion every three weeks pay for a visit home by the worker or, in lieu of this, authorize subsistence payments or Residence accommodation for up to two nights plus transportation costs for a spouse, relative or other person from the worker's residence with a close personal attachment to the worker visiting the worker. Where the trip involves travel outside of British Columbia, the Board will prorate the airfare on a mileage basis and only pay the portion from the British Columbia border. This proration may, at the discretion of a Director in the Compensation Services Division, be waived in the case of a spouse, relative or other person from the worker's residence with a close attachment to the injured worker who is visiting a worker in critical condition in a hospital.

[1] The "Claims Department" no longer exists.

The payment of transportation costs includes the costs of meals where necessary. Any visit home not meeting the above criteria must be at the worker's own expense. No subsistence allowances will be paid if a worker elects not to return home but lives elsewhere than the Residence over a weekend.

5. Where the Adjudicator feels that there are other circumstances where subsistence or Residence accommodation for a person with a close attachment to the injured worker is appropriate, one night may be allowed and the reason for so doing noted on the claim with a copy sent to a Director in the Compensation Services Division. Where a longer stay is felt to be appropriate, the Adjudicator may request subsistence or Residence privileges from a Director in the Compensation Services Division. In these cases, the reasons and the claim should be forwarded for decision but this requirement may be dispensed with at the discretion of a Director in the Compensation Services Division.
6. Where a spouse attends a chronic pain clinic at which the claimant is being treated, travelling expenses and subsistence allowances are payable.

The Claims Adjudicator will normally accept the judgment of the attending physician as to whether a travelling companion should accompany the claimant or whether the worker's condition is considered critical.

#83.12 Visits Home by Worker

Where under Board sponsorship, a worker is undergoing a program of retraining away from her or his residence and the course of retraining is one of six weeks or more duration, the same provisions as listed in #83.11, item 4 apply.

#83.13 Income Loss

In situations where a worker who is not deemed disabled from working loses time from work to attend treatment or examination by a physician or qualified practitioner or for other authorized treatment, a payment through health care benefit funds can be made. These situations will either involve a worker who has never been declared disabled as the result of the injury or occupational disease, or has returned to work following a period of disability, but is still undergoing treatment. The payment is normally equal to 75% of the worker's actual current loss. However, it is subject to the same rules as to the maximum and minimum as are applicable to temporary total disability benefits. (See #34.20 and #69.00.)

Such payments are made where it is deemed unreasonable for the worker to attend for the examination(s) or treatment(s) outside of working hours. Generally, there will be no reimbursement if the loss incurred is under two hours, however, multiple losses, which in the aggregate accumulate to a significant loss,

may qualify for payment. While these payments are not wage-loss compensation, the provisions of Section 5(2) of the *Workers Compensation Act* will be followed. As such, no income-loss subsistence will be paid for losses incurred on the day of the injury.

If a loss is due either to the worker's personal selection of a physician or qualified practitioner which involves bypassing closer treatment facilities, this will be taken into account when evaluating an entitlement to income-loss subsistence.

In situations where the worker is maintained on full salary by the employer and an entitlement to income-loss subsistence has accrued, the payment will be made to the employer under the terms of Section 34 of the *Workers Compensation Act*.

#83.20 Rates of Subsistence

"Subsistence" means the costs of accommodation and meals.

The Board will normally reimburse actual accommodation costs. (In the case of visits to Richmond, workers will be accommodated in the Richmond Residence.) When contacting the worker prior to departing from home, the Board officer will 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

CHAPTER 11

VOCATIONAL REHABILITATION SERVICES

85.00 INTRODUCTION

Section 16 of the *Workers Compensation Act* is the guiding legislation of Vocational Rehabilitation Services.

The Vocational Rehabilitation Consultant is the service coordinator.

The Vocational Rehabilitation Services Advisory Council facilitates consultation with members of the community served by the Board.

#85.10 Legislative Mandate

Section 16 of the *Workers Compensation Act* states:

"(1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the board may take the measures and make the expenditures from the accident fund that it considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

(2) Where compensation is payable under this Part as the result of the death of a worker, the board may make provisions and expenditures for the training or retraining of a surviving dependent spouse, regardless of the date of death.

(3) The board may, where it considers it advisable, provide counselling and placement services to dependants."

#85.20 Quality Rehabilitation

Quality rehabilitation requires individualized vocational assessment, planning, and support provided through timely intervention and collaborative relationships to maximize the effectiveness of rehabilitation resources and worker-employer outcomes.

#85.30 Principles of Vocational Rehabilitation

The guiding principles of quality vocational rehabilitation are:

1. Vocational rehabilitation should be initiated without delay and proceed in conjunction with medical treatment and physical rehabilitation to restore the worker's capabilities as soon as possible.

2. Successful vocational rehabilitation requires that workers be motivated to take an active interest and initiative in their own rehabilitation. Vocational programs and services should, therefore, be offered and sustained in direct response to the commitment and determination of workers to re-establish themselves.

3. Maximum success in vocational rehabilitation requires that different approaches be used in response to the unique needs of each individual.

4. Vocational rehabilitation is a collaborative process which requires the involvement and commitment of all concerned participants.

5. Effective vocational rehabilitation recognizes workers' personal preferences and their accountability for independent vocational choices and outcomes.

6. The gravity of the injury and residual disability is a relevant factor in determining the nature and extent of the vocational rehabilitation assistance provided. The Board should go to greater lengths in cases where the disability is serious than in cases where it is minor, including measures to assist workers to maintain useful and satisfying lives.

7. Where the worker is suffering from a compensable injury or disease together with some other impediment to a return to work, rehabilitation assistance may sometimes be needed and provided to address the combined problems. Rehabilitation assistance should not be initiated or continued when the primary obstacle to a return to work is non-compensable.

#85.40 Service Objectives

The objectives of Vocational Rehabilitation Services are:

1. To assist workers in their efforts to return to their pre-injury employment or to an occupational category comparable in terms of earning capacity to the pre-injury occupation.

2. To provide the assistance considered reasonably necessary to overcome the immediate and long-term vocational impact of the compensable injury, occupational disease or fatality.

3. To provide reassurance, encouragement and counselling to help the worker maintain a positive outlook and remain motivated toward future economic and social capability.

#85.50 Services Provided

The objectives of Vocational Rehabilitation Services are met by providing the following services to its clients:

- counselling;
- vocational assessment and planning;
- job readiness/skill development;
- placement assistance;
- residual employability assessment.

#85.60 Departmental Mandate

In accordance with the principles of vocational rehabilitation, the department achieves its legislative mandate by providing quality rehabilitation to its clients.

#86.00 ELIGIBILITY

Rehabilitation assistance may be provided in cases where it appears to the Vocational Rehabilitation Consultant that such assistance may be of value, and where a decision has been made that the injury, occupational disease or death is compensable. Where an adjudication decision is pending, the guidelines set forth in #86.70 apply.

The majority of referrals for rehabilitation services are initiated by the Claims and Disability Awards Departments. Workers may also be referred directly by physicians, hospitals, union representatives, employers and other agencies, or may seek assistance themselves.

The Vocational Rehabilitation Consultant determines the nature and the extent of the rehabilitation services to be provided.

#86.10 Referral Guidelines

The following guidelines are used by Board officers in making referrals to the Vocational Rehabilitation Consultant. Internal referrals clearly identify what has been accepted under the claim and specify reasons for the referral, including new information warranting repeat referral.

#*86.11 Immediate Referrals*

1. Spinal cord injuries resulting in paraplegia or quadriplegia.

2. Major extremity amputations or severe crush injuries.

3. Severe brain or brain stem injuries.

4. Significant burns (e.g. 20% of the body surface, or third-degree burns of 10% or more of the body surface).

5. Significant loss of vision.

6. Fatalities.

#*86.12 General Referrals*

1. Claims where medical evidence indicates that the worker will experience difficulty in returning to the pre-injury employment. This would include vocational concerns arising from an uncertain medical prognosis or lengthy period of convalescence.

2. Claims in which an occupational disease affects the worker's ability to return to prior employment.

3. Claims where the pre-injury employment is no longer available because of the length of time the worker has been on compensation.

4. Claims where a return to the pre-injury occupation with the disability would put the worker at a long-term disadvantage compared with others in that occupation.

5. Requests made by the Board officer in Disability Awards for employability assessments under policy item #40.10 and policy item #40.12 and commutation investigations under policy item #45.50.

6. Investigations for the consideration of temporary partial disability benefits under section 30 of the *Act*, as set forth in policy item #35.11.

7. Consideration for continuity of income benefits under policy item #89.11 pending assessment of a permanent disability pension.

8. Consideration for Homemakers' Services under policy item #84A.00.

9. Consideration for Personal Care Allowances under policy item #80.00.

10. Consideration for Independence and Home Maintenance Allowances under policy item #81.00.

11. Claims where recovery or re-employment is affected by:

    (a) psychological/social problems;

    (b) emotional problems;

    (c) financial stress;

    (d) substance abuse; and

    (e) vision/hearing problems.

EFFECTIVE DATE: March 3, 2003 (as to deletion of reference to pension review)
APPLICATION: Not applicable.

#86.20 Non-compensable Problems

Where the worker is suffering from a compensable injury or disease together with some other impediment to a return to work (e.g. substance abuse), rehabilitation assistance may sometimes be needed and provided to address the combined problems.

Rehabilitation assistance should not be provided when the primary obstacle to a return to work is non-compensable.

#86.30 Preventative Rehabilitation

Preventative rehabilitation is intended to provide assistance to workers who can return to their old jobs, but have been medically deemed to be at undue risk of:

1. permanent disability due to vulnerability, or

2. increased permanent disability.

Cases involving occupational disease or prior claims for the same injury (mainly joints and backs) are the primary focus of preventative rehabilitation.

Once eligibility for preventative assistance has been established, the rehabilitation process set forth in #87.00 applies.

#86.40 Injuries Caused by Third Parties

In the case of third-party claims, where workers have a right of election, they are not eligible for rehabilitation assistance until they have elected to claim compensation with the Board. (See #111.20.)

#86.50 Out of Province

Rehabilitation services requested of, or by, other Canadian Boards and Commissions are coordinated through reciprocal inter-jurisdictional agreement.

#86.60 Other Acts Administered

Rehabilitation services are provided under the terms of the provincial *Criminal Injury Compensation Act* and the federal *Government Employees Compensation Act*.

#86.70 Continuation of Assistance

In cases where the severity of an injury warrants immediate referral, intervention may precede the formal acceptance of the claim. Where this occurs, no substantial expenditures are initiated prior to acceptance of the claim. Should the claim be denied, any vocational rehabilitation assistance already being provided will terminate within 15 days unless a request for a review by the Review Division has been filed. In such cases, assistance may be continued pending disposition of the review.

Once a decision has been made that an injury or disease is compensable, there is no requirement that vocational rehabilitation assistance end at the same time wage-loss compensation is concluded. The worker may no longer be eligible for temporary disability benefits, but vocational assistance may still be required and, where necessary, should be provided.

EFFECTIVE DATE: March 3, 2003 (as to reference to Review Division)
APPLICATION: Not applicable.

#87.00 REHABILITATION PROCESS

The vocational rehabilitation process addresses the individual needs and circumstances of each worker. Ongoing medical opinion and a variety of Board and community resources assist the Vocational Rehabilitation Consultant and

the worker in developing a rehabilitation plan. The principles regarding medical opinion set forth in #97.30 apply equally to the rehabilitation process.

#87.10 Consultative Process

The Vocational Rehabilitation Consultant functions as a catalyst, coordinator, initiator and expediter of all the disciplines involved in helping a worker to overcome the effects of a compensable injury/occupational disease. This demands a team approach which involves the injured worker, other Board officers, medical practitioners, employers, union representatives, other agencies and members of the worker's family.

The rehabilitation process emphasizes ongoing consultation with the worker, the employer and, where applicable, the union, in order to maximize and maintain all opportunities for suitable re-employment.

The consultative process is guided by the Vocational Rehabilitation Consultant in response to the worker's determination for vocational success.

While it is up to the Consultant to assess workers' needs and appropriate levels of rehabilitation assistance, it is ultimately the responsibility of workers to decide their own vocational future.

In order to carry out the disclosure of information necessary to administer this consultative process, a consent from the worker will normally be requested in advance.

#87.20 Operational Process

The rehabilitation process involves five sequential phases of vocational exploration. The Vocational Rehabilitation Consultant expedites this process in accordance with the principles and service objectives set forth in #85.30 and #85.40 respectively.

PHASE I

Principle:

All efforts will be made to help the worker return to the same job with the same employer.

Rationale:

The worker returns to a known environment, maintains seniority and company benefits and, where applicable, remains in the same union.

The employer benefits by virtue of retaining a trained and experienced employee.

Method:

Programs of physical conditioning, work assessment, refresher training or skill upgrading may be appropriate.

PHASE II

Principle:

Where the worker cannot return to the same job, the employer will be encouraged to accommodate job modification or alternate in-service placement.

Rationale:

As in Phase I, the worker and the employer mutually benefit from the continuation of the employment relationship.

Method:

Programs relevant to Phase I may be appropriate. In addition, work site/job modification and/or supplementary skill development involving training-on-the-job and/or formal training may be required.

PHASE III

Principle:

Where the employer is unable to accommodate the worker in any capacity, vocational exploration will progress to suitable occupational options in the same or in a related industrial sector, capitalizing on the worker's directly transferable skills.

Rationale:

The worker returns to a known or related industry which best utilizes existing skills to optimize occupational potential. This may also allow the worker to retain union status where applicable.

Method:

The programs relevant to the preceding phases may be applicable. In addition, job search assistance may be indicated.

PHASE IV

Principle:

Where the worker is unable to return to alternate employment in the same or related industry, vocational exploration will progress to suitable occupational opportunities in all industries, recognizing the worker's inventory of transferable skills, aptitudes and interests.

Rationale:

The worker returns to suitable employment in a different industry which best utilizes existing skills to optimize occupational potential.

Method:

All programs relevant to the preceding phases may apply.

PHASE V

Principle:

Where existing skills are insufficient to restore the worker to suitable employment, the development of new occupational skills will be considered.

Rationale:

The worker is equipped with new marketable skills with a view to optimizing occupational potential.

Method:

Training programs will be considered for the development of new occupational skills. Programs relevant to the preceding phases may apply to help the worker secure employment once trained.

#88.00 PROGRAMS AND SERVICES

The programs and services offered by the Board in support of vocational rehabilitation can be implemented individually or in combination as part of an overall rehabilitation plan. The nature and extent of program sponsorship is decided in accordance with the principles set forth in #88.51.

The vocational plan is agreed to and summarized in a letter of understanding which is normally signed by the Vocational Rehabilitation Consultant, the worker,

and where appropriate the employer, to acknowledge the commitments and expectations of all parties.

Wage-loss equivalency benefits provided by Vocational Rehabilitation Services are payable only when wage-loss benefits have concluded and follow the same rules with regard to the deduction of pensions. (See #69.10 to #70.30.) These benefits may apply while workers are either awaiting or undertaking specific vocational programs.

Transportation and subsistence allowances and accommodation at the Board's Rehabilitation Residence, as discussed in #82.00 to #84.00, may also be considered in support of vocational programs.

The sponsorship opportunities of other agencies are considered in providing integrated service delivery, but their availability does not diminish the Board's primary service and funding responsibilities.

#88.10 Work Assessments

A work assessment program is a method of determining or enhancing a worker's employment capabilities and potential in an actual work environment with an employer, or in the simulated setting of the Board's Functional Evaluation Unit.

#88.11 Guidelines

1. Work assessments may be utilized at any phase of the rehabilitation process.

2. While involved in a work assessment with an employer, the worker is not being paid wages. Therefore, participating employers are not required to make deductions for Income Tax, Employment Insurance benefits or Canada Pension Plan contributions.

3. When a work assessment with an employer takes place prior to full medical recovery and is intended primarily as a therapeutic measure to assist increasing levels of work activity, the program is normally referred to as a "Graduated Return to Work". This program is commonly a first step in a worker's successful reinstatement with the pre-injury employer.

4. Work assessments also allow employers and workers to assess the viability of employment in a particular job and are frequently used together with training-on-the-job programs.

#*88.12 Expenditures*

1. The Board provides financial assistance to workers who are participating in work assessment programs, either through a continuation of wage-loss benefits under Section 29 or 30 of the Act, or payment of rehabilitation allowances under Section 16 when wage-loss benefits are no longer payable.

2. Costs arising from injuries or aggravations that occur during the course of Board-sponsored work assessments with an employer are not charged to the participating employer.

#88.20 Work Site and Job Modification

The Board may provide assistance to alter work sites or modify jobs to facilitate re-employment in physically appropriate working conditions.

#*88.21 Guidelines*

1. Assistance of this nature may occur at any phase in the rehabilitation process where it is advantageous in returning workers to employment.

2. Modifications are considered and undertaken in consultation with workers, employers, unions and treating professionals.

#*88.22 Expenditures*

1. The Board may provide financial assistance for the modification of jobs and work sites, including expenditures for special equipment and/or tools, if appropriate and necessary in facilitating the worker's return to employment.

2. In some instances, it may be appropriate to share the costs of these expenditures with employers.

#88.30 Job Search Assistance

Job search assistance may be provided to workers who require help in securing appropriate employment.

#*88.31 Guidelines*

1. Job search assistance would normally be introduced at Phase III of the rehabilitation process (see #87.20) to help equip workers with the

knowledge and skills to conduct a successful search for employment. Assistance may include:

(a) vocational assessment and goal-setting through individual and/or group counselling;

(b) referral to internal and external employment resources;

(c) marketing to prospective employers;

(d) financial assistance.

2. Eligibility for job search assistance and its continuance is conditional upon the active cooperation of the worker with the Vocational Rehabilitation Consultant. Workers may be required to provide proof that they are earnestly seeking employment, or awaiting a definite job opportunity.

#*88.32 Expenditures*

1. The Board may provide financial assistance in the form of a job search allowance. This is a discretionary benefit which applies if the worker is actively seeking or returning to appropriate employment, attending a designated job search program, or awaiting a confirmed job opportunity. The amount of the allowance will not exceed wage-loss equivalency.

2. When employment is not available locally, but is secured in another locale, the Board may pay the cost of moving household effects.

#88.40 Training-on-the-Job

Training-on-the-job is a shared-cost program which is undertaken at an employer's work site to provide the worker with specific skills leading directly to employment.

#*88.41 Guidelines*

1. Training-on-the-job assistance may be provided at any phase of the rehabilitation process. It may enhance or develop new occupational skills.

2. While the worker is undertaking a training-on-the-job program, absences are usually treated according to the training employer's policy on absenteeism. That is, if the employer deducts the worker's

pay for an absence, so will the Board. If the employer pays for the absence, the Board will pay as well.

#88.42 Expenditures

1. Financial assistance for a training-on-the-job program will normally be provided on a shared-cost basis with the training employer. The Board's contribution will usually decrease, on a sliding scale, as the program proceeds and the worker's productivity increases. The portion of the worker's wages paid by the Board will normally not exceed the worker's wage-loss rate.

   Training-on-the-job allowances will be calculated in a manner similar to the calculation of temporary disability benefits. In general the sum of the wages from the training employer and the gross payments from the Board to the worker will be equal to the worker's pre-injury wage rate. Where the worker's pre-injury wage rate exceeds the maximum wage rate as set under Section 33(10) of the Act, the Board's contribution will be calculated by substituting the maximum wage rate for the pre-injury wage rate. In that case the sum of the wages from the training employer and the gross payments from Board to the worker will be equal to the maximum wage rate.

2. Expenditures under this program will usually be paid directly to the employer, so that the worker will be covered by Employment Insurance, Canada Pension Plan and any other company benefits.

3. Disability pensions are not deducted from training allowances for training-on-the-job programs when paying the employer.

4. Nothing in this item should be interpreted to prohibit the Board from negotiating a wage with the training employer which exceeds either the maximum wage rate or the worker's pre-injury wage. The Board will seek to maximize the wages paid to the worker by the training employer while recognizing that it is necessary and desirable to provide some incentive to employers to choose injured workers for training-on-the-job positions.

#88.43 Injury in the Course of Training-on-the-Job

The Board considers it essential to encourage employers to provide training and employment opportunities for injured workers. One way of doing this is to exclude from the employer's experience rating (see #115.30) the costs of certain employment injuries and aggravations occurring in the course of a training-on-the-job program.

There are two different training-on-the-job situations to be considered:

1. The employer is not paying the worker; the Board is paying full benefits.

   The position is as in #88.54. This means that all costs resulting from the aggravation of the injury are excluded from experience rating, whatever the nature of the injury.

2. The employer is paying a partial wage to the worker who is also receiving payments from the Board; or the Board is reimbursing the employer part of the worker's salary.

   If there is an aggravation of the old injury, or the old injury contributes significantly to the occurrence of the new injury, all the resulting costs are excluded from experience rating, whatever the nature of the injury.

   If the old injury made no significant contribution to the new injury, the Board will exclude from experience rating a proportion of the costs of the new claim equal to the percentage of the worker's wages being paid or reimbursed by the Board.

The above policy applies whether the employer at the time is a new employer or the worker's original employer.

In addition to relief for the individual employer for experience rating, the employer's sector or rate group may be eligible for relief under Section 39(1)(e) (see #114.40) where the disability lasts more than 13 weeks.

#88.50 Formal Training

Formal training refers to courses or programs which:

1. add to, or upgrade a worker's existing skills or qualifications;

2. provide new occupational skills.

These may include full-time or part-time trades, technical or academic programs offered through recognized training or educational institutions.

#88.51 Levels of Support

Where a worker, who has sustained a compensable injury or occupational disease, wishes to undertake a formal training program and seeks assistance from the Board, the proposed program must be classified in one of the following three categories:

1. Training Related Directly to the Disability

   The Board should provide the cost of any formal training program considered reasonably necessary to overcome the effects of any residual disability. This can also apply to preventative rehabilitation under #86.30.

   (a) The primary guideline is that the Board should, where practical, support a program sufficient to restore the worker to an occupational category comparable in terms of earning capacity to the pre-injury occupation.

   (b) A secondary guideline is that the gravity of the residual disability is a relevant factor. The Board should go to greater lengths in cases where the residual disability is serious than in cases where it is minor.

   Where a worker is eligible for a formal training program under this heading, the support provided under Section 16(1) of the Act should be sufficient to enable the worker to complete the program. Workers should not be expected to use their own resources or to commute their pension for this purpose.

2. Training Related Partly to the Disability

   Workers may sometimes want to blend their rehabilitation into a general advancement of their education, or pursue a vocational ambition which exceeds what would otherwise be provided under Section 16(1) of the Act.

   For example, a worker is injured in a heavy manual occupation and is unable to return to heavy manual work. In discussion with the Vocational Rehabilitation Consultant, it appears that there is a two-year technical training program that would provide occupational skills for a position with earning capacity and prospects at least as good as the pre-injury occupation; but rather than pursue this option the worker prefers a more extensive four-year university program.

The Board should not deny the rehabilitation assistance that would have been provided if the worker had chosen the two-year technical training program, but neither should it generally finance an educational advancement that goes beyond what is reasonably necessary as rehabilitation for the injury.

In cases of this kind, the Board will estimate the total expenditure that would have been incurred under Section 16(1) of the Act if the worker had taken a program considered reasonably necessary to overcome the effects of the compensable injury. The worker will then be offered that amount as a contribution to the cost of the preferred vocational plan.

If the injury is very severe, the Board might treat the case under Category 1 and support the whole program. Rehabilitation is not limited to restoring earning capacity and, in cases of catastrophic or very serious injury, the Board should do all that is reasonably possible and appropriate to facilitate the functional restoration and development of the worker. In these cases, a formal training program may be wholly supported by the Board notwithstanding:

(a) that it goes beyond what is necessary to restore the pre-injury earning capacity of the worker, or

(b) that it may not improve earning capacity at all.

3. Training Unrelated to the Disability

Sometimes, recovery from an injury coincides with a desire for a change of occupation, or for some formal training program which the worker might well have undertaken regardless of the injury. The jurisdiction of the Board under Section 16(1) of the Act is to provide assistance reasonably necessary as rehabilitation for a compensable injury. Thus, it is not a function of the Board to finance training that is part of an ordinary career pattern or that is desired by the worker for reasons unrelated to the injury.

Such training would, therefore, not be supported under Section 16(1). If the worker wished to meet the cost of the program by a commutation of a pension, that is something the Board might consider under #45.44.

#*88.52 Guidelines*

1. Formal training may be considered at any phase of the vocational rehabilitation process.

2. Formal training programs are normally undertaken for the purpose of improving a worker's long-term employment and earnings potential.

3. Before deciding on a formal training program, it is important that the worker's desires, abilities, aptitudes, interests and educational

readiness are assessed in order to ensure a probability of success. The program must also be compatible with the worker's physical capabilities and any ongoing medical treatment.

4. Decision-making regarding the type and appropriateness of formal training programs is a collaborative process which takes into consideration the desire and intent of the worker and all relevant assessment and labour market information. The Vocational Rehabilitation Consultant determines the feasibility of the program(s) under consideration and decides whether to recommend sponsorship.

5. Ongoing support and sponsorship of formal training programs are contingent upon the worker's active cooperation and participation in the process. If the worker does not meet the attendance and progress requirements of the program, financial sponsorship may be suspended or withdrawn. Discussion with the worker will determine whether further or alternate assistance is appropriate.

#88.53 *Expenditures*

When it is decided to support a formal training program related directly to the disability, the assistance provided under Section 16(1) of the Act will normally include:

1. Training allowances at wage-loss equivalency when enrolled in a full-time program.
2. Tuition fees and any necessary books, materials or equipment.
3. Travel and subsistence where appropriate under #82.00 to #84.00.

When it is decided to support a formal training program related partly to the disability, the Board will estimate the total expenditure that would otherwise have been incurred under Section 16(1) of the Act. The worker will then be offered that amount as a contribution to the cost of the preferred program. This contribution will normally be paid by installments for the duration of the program. The installments will be subject to cost-of-living adjustments using the formula provided in Section 25 of the Act.

#88.54 *Injury in the Course of Training*

A worker undergoing a course of rehabilitation training sponsored by the Board does so in the circumstances described below:

1. The trainee may be attending a school of training specifically operated as such and for which course of training the Board pays a fee to the school, while at the same time paying the trainee the allowance prescribed by Board regulations.

2. A trainee may, by arrangement, be receiving training in an industrial or business establishment, receiving no remuneration from the employer in the establishment, but only receiving the allowance prescribed by Board regulations. At the same time, the Board may be paying something by way of a training fee to the employer in the establishment.

In the above circumstances, the Board takes the position that the trainee is not a "worker" employed by the participating employer in the course of rehabilitation training. Should the trainee receive further injury in the course of training, the Board regards such further injury as a continuation of the original disability. The two main objectives are:

1. that the injured trainee shall receive compensation benefits under the Act, and
2. that an employer who cooperates and assists the Board in rehabilitating an injured worker shall not be penalized for so doing.

In case of an aggravation or new injury to a trainee, the Board will normally exclude the costs from the employer's experience rating (see #115.30). In addition, the employer's sector or rate group may be eligible for relief under Section 39(1)(e) (see #114.40) where the disability lasts more than 13 weeks.

The above policy applies whether the employer at the time is a new employer or the worker's original employer.

#*88.55 Joint Sponsorship*

Where a worker is undertaking a training program sponsored by another agency, and:

1. the circumstances are such that a similar program would have been supported by the Board, and
2. the level of support provided by the other agency is less than would have been provided by the Board,

the Board will provide support to the extent of the difference.

#88.60 Business Start-ups

The Board may contribute to the cost of starting or enhancing a viable business for a worker in lieu of other rehabilitation measures. The amount of financial assistance will normally not exceed the amount that would have been paid if the claimant had undertaken a vocational program considered reasonable and necessary to overcome the effects of the compensable injury.

When considering vocational rehabilitation expenditures for business start-ups, the basic guidelines set forth in #45.43 apply.

#88.70 Legal Services

While legal assistance is not normally required as a rehabilitation measure, the provision of legal assistance might be considered, where appropriate, as part of the worker's rehabilitation offered under Section 16 of the Act, either at the request of the worker or at the initiative of an officer of the Board.

Legal advice is not provided in respect of any matter that the Board is or may be adjudicating.

The following examples illustrate some of the circumstances in which legal assistance by the Board may be considered.

1. Indebtedness or Insolvency

   Where claims are being made against a worker which are an impediment to recovery from an industrial injury or disease, the provision of legal advice by the Board might be considered as part of the worker's rehabilitation.

2. Matrimonial Problems

   Cases sometimes arise in which the threat of wage garnishment for the enforcement of a maintenance order is a cause of anxiety, or in other respects an impediment to a return to work. Legal assistance by the Board in these circumstances is a possibility that might be considered.

3. Conveyancing

   A worker who owns a home may be required by the nature of the injury to move (e.g. paraplegia). In such a case, conveyancing services might be considered as part of the rehabilitation assistance and this may be done within the Legal Services Division of the Board or in the form of paying the fees and disbursements for a lawyer in private practice.

4. Workers' Estates

   Where workers suffer serious injuries that render them unable to administer their own affairs, their family may need legal advice and assistance to make alternative arrangements.

5. Advice to a Surviving Spouse

   The Board cannot provide any legal assistance that may be required in relation to the administration of an estate of a deceased worker. Nor can the Board provide legal assistance in relation to any other problems resulting directly from a death; but if any legal problems should arise in relation to the employment of dependants, legal advice

in respect of such problems might be considered as one aspect of counselling.

6. Other Situations

   The examples set out in this item are mentioned only by way of illustration. They are not an exhaustive list of the circumstances in which legal assistance might be provided.

#89.00 EMPLOYABILITY ASSESSMENTS

One of the major functions of the Vocational Rehabilitation Consultant is to assist in the assessment of employability for permanent disability and for temporary partial disability under Sections 23(3) and 30(1) of the *Workers Compensation Act*.

#89.10 Permanent Partial Disability

The Board applies a dual system in assessing permanent partial disability pensions. One of the systems involves a projected-loss-of-earnings method. This method is governed by the principles set forth in #40.00 and requires an employability assessment.

Requests for employability assessments are made by the Adjudicator in Disability Awards in those cases where it is felt that because of a compensable disability the worker may sustain a loss of earnings which is greater than that compensated for by the physical impairment method of pension assessment. (See #39.00.)

The evidence of the Vocational Rehabilitation Consultant should relate to occupations that are suitable and reasonably available to the worker over the long-term future. The conclusion of the Adjudicator should be concerned with those occupations which will maximize the worker's long-term earnings potential. The occupations that are recommended as being suitable for the worker in calculating a loss-of-earnings pension need not be available at the time the recommendation is prepared, but should be reasonably available to the worker in the long run. The guidelines for determining suitable and reasonably available occupations are set forth in #40.12. Future employment and earning potential is assessed in light of all possible rehabilitation measures under #87.00 that may be of assistance and appropriate to the circumstances of each worker.

#89.11 Continuity of Income Pending Assessment of Permanent Disability Pension.

The Board may pay a rehabilitation allowance to assist workers who are not actively engaged in the rehabilitation process but who are awaiting assessment of their disability pension. This allowance will be considered for workers

- whose disability has stabilized,
- who are unemployed or, effective July 16, 1998, employed at a reduced income level due to their compensable disability,
- who are not entitled to temporary wage-loss benefits,
- who are not receiving other wage-loss equivalency benefits from the Board, and
- who are likely to receive either a significant permanent partial disability pension award based upon the Permanent Disability Evaluation Schedule or a pension calculated on the worker's potential loss of earnings under Section 23(3).

In view of their obvious need, these cases will be given priority handling in the assessment of their pension entitlement. Consideration will be given to the payment of a rehabilitation allowance between the end of wage-loss or other wage replacement payments and the commencement of the permanent disability pension. These income continuity payments will be considered by the Vocational Rehabilitation Consultant following discussions with the Case Manager and other appropriate Board officers.

Prior to implementing an income continuity payment, the Vocational Rehabilitation Consultant must have considered and offered to the worker all rehabilitation measures which are reasonable and might be of assistance to the worker.

#89.12 Amount of payment

Effective September 1, 1996, continuity of income payments will be based initially on the same rate as the wage-loss benefit rate and will continue at that level until the pension is awarded, except in any of the following circumstances:

1. The worker has retired.
2. The worker is experiencing non-compensable medical, psycho-social or financial problems which preclude active participation in the rehabilitation process.
3. The worker refuses to actively participate in the rehabilitation process.

In the above circumstances, the Vocational Rehabilitation Consultant will complete the employability assessment required under the Board's dual system for assessing permanent disability pensions, and will provide a copy of that assessment to the worker. Thirty (30) days after the worker has been provided with a copy of the employability assessment, the Vocational Rehabilitation Consultant will adjust the income continuity rate to the rate which best reflects the conclusions contained in the employability assessment regarding the worker's projected long-term earning capacity. However, the Vocational Rehabilitation Consultant will not adjust the rate at this point if, during the 30-day period based on new evidence, the Vocational Rehabilitation Consultant decides the employability assessment requires revision.

As part of the completion of the employability assessment and prior to adjusting the income continuity rate, the Vocation Rehabilitation Consultant must investigate the worker's circumstances and must consider the impact of the compensable disability on the worker's decision to retire or not to participate in the rehabilitation process.

In all cases where the income continuity rate is adjusted as provided for above, the Vocational Rehabilitation Consultant will have regard to the guidelines set out in #40.12 in determining the appropriate rate.

#89.13 Continuity of Income Payments

Effective July 16, 1998, continuity of income payments will also be considered for workers who are already receiving a permanent disability pension on the claim, where the Board has reopened the pension decision and it is likely that the worker will receive a significant increase in the existing pension. As well, there must be evidence of a deterioration in the worker's medical condition which is likely to be permanent, and the worker must be experiencing a reduction in income during the period which is related to the reasons for the pension reopening. Benefit levels will be established in accordance with the guidelines set out in policy items #89.11 and #89.12.

EFFECTIVE DATE: March 3, 2003 (as to reference to reopening)
APPLICATION: Not applicable.

#89.20 Temporary Partial Disability

Where a worker is medically judged to be only partially disabled and the condition remains temporary, any further wage-loss payments may be processed under Section 30 of the Act. In such cases the claim is referred immediately to a Vocational Rehabilitation Consultant for assessment in accordance with the guidelines set forth in #35.20 and #35.21.

The wording of the Act makes a distinction between Sections 30 and 23(3) in determining what jobs are available to a worker. Section 30, in reference to short-term temporary disability, uses the words "in some suitable employment",

whereas Section 23(3), in reference to permanent disability, states “in some suitable occupation”. The word “employment” has a connotation of immediacy while “occupation” suggests a long-term concept. Therefore, in determining Section 30 benefits, the employment opportunity or opportunities should be available immediately or within the period under review (two weeks, one month) and there should be some certainty that workers would have these opportunities open to them should they choose to apply.

Where the Vocational Rehabilitation Consultant and the worker are engaged in carrying out a rehabilitation plan, and all parties are cooperating in good faith, the Consultant is not required to recommend that temporary partial disability benefits be based on short-term, temporary or lesser paying jobs that the worker could do, but which would be incompatible with the demands and commitment required to meet the overall vocational objective.

#90.00 SPINAL CORD AND OTHER SEVERE INJURIES

The rehabilitation program for workers with spinal cord, and other injuries of similar severity, has the same objective as any other rehabilitation program, namely to assist the worker in achieving physical, psychological, economic, social and vocational rehabilitation. Because of the severity of these disabilities, greater assistance is required than for most other disabilities.

The assistance provided by the Board may include vehicle modifications, house renovations, Personal Care Allowances, Independence and Home Maintenance Allowances and Homemakers’ Services. (See Chapter 10.) Service requirements are assessed and recommended by the Vocational Rehabilitation Consultant.

In cases where quadriplegics or paraplegics with upper limb involvement are faced with additional expenses to purchase special vehicles for transportation, the Board may approve a lump-sum payment on a “one time only” basis according to the needs of the individual.

#90.10 Head Injuries

One of the Board’s objectives is to assist workers who have sustained serious head injuries to successfully reintegrate into the workplace, community or family environment. Quite often these workers have significant deficits or behavioural problems which need to be overcome or controlled to avoid family conflict or institutional care.The main focus of vocational rehabilitation involvement in such cases is to help maximize the functional restoration and development of the worker.

#91.00 VOCATIONAL ASSISTANCE FOR SURVIVING SPOUSES AND DEPENDANTS OF DECEASED WORKERS

Where a worker's death is compensable, the Board has statutory authority to provide counselling and placement services to the surviving spouse and dependants. In addition, the Board has authority to make expenditures for the training of the dependent spouse. The Board takes the initiative in determining the need and extent of these services.

#91.10 Sponsorship of Training for Surviving Dependent Spouses

The Board may offer training assistance to a dependent spouse where the training is designed to improve the spouse's earning capacity or effectiveness in the labour market generally.

#*91.11 Eligibility*

1. Spouses who receive periodic pension awards and those who receive capital sum awards are eligible for training assistance.

2. Sponsorship of training will be considered for spouses who were not employed at the time of the worker's death, or were employed in occupations with limited financial prospects. Spouses employed in occupations with established career patterns at the time of the worker's death will not generally be considered for training assistance. Where the spouse was in a career pattern prior to the marriage, and has the qualifications to return to that career pattern, the Board would not normally support training except where the qualifications required updating or upgrading to permit a return to that career pattern.

3. The spouse's need for training will be a prime consideration in making a decision to sponsor a training program. This need will be assessed according to such factors as the length of time that the spouse has been out of the labour force, the impact of new technology on the spouse's former occupation, and the financial impact of the worker's death on the household. If the spouse has job-ready skills in an occupation that has reasonable prospects, training assistance will not normally be provided.

4. The spouse's eligibility for training sponsorship may be considered regardless of the date of the worker's death. The Board would normally expect decisions under Section 16(2) of the Act to be made within a year of the death. Any request received after that time would

not necessarily be denied, but the Board would be less likely to conclude that the training was needed as a result of the death.

#91.12 *Guidelines*

1. Before agreeing to sponsor a specific training program, the Vocational Rehabilitation Consultant should determine that the spouse meets the entry requirements for the training program and has a reasonable prospect of completing the program successfully.

2. Assistance under Section 16(2) of the Act is not limited to any particular kind of training, except that, to be consistent with the general policy and objectives of the Act, the program should be one which helps to improve the earning capacity of the spouse. Thus, in one case, it may be a vocational training program for a particular occupation; in another case, it may be a training course designed to improve the effectiveness of the spouse in the labour market generally.

3. With regard to a university or higher educational program, the Board may include this for support under Section 16(2) where it appears to be needed to overcome the effect of the worker's death; but this would not involve support of a university program on an indefinite basis. Normally, the support would not extend further than one educational level beyond the qualifications that the spouse has when the matter is considered.

4. For assistance to be rendered, it is not necessary that there should be any application. Assistance under Section 16(2) may result from an application by the surviving spouse, or it may result from an initiative and proposal by the Rehabilitation Consultant, or others concerned with the claim, with which the surviving spouse may agree.

5. The sponsorship opportunities of other agencies are considered in providing integrated service delivery, but their availability does not diminish the Board's primary service and funding responsibilities.

#91.13 *Expenditures*

Sponsorship of formal training programs under Section 16(2) of the Act will normally include payment of:

1. Tuition fees and necessary books, materials or equipment.

2. Travel and subsistence expenses and homemaker allowances, including child care, where appropriate under #82.00 to #83.20 and #84A.00.

3. An additional living allowance may be paid as follows:

   (a) A surviving dependent spouse who is eligible for a capital sum under #55.32 should not be expected to use that sum for maintenance while undertaking a program of training needed as a result of the worker's death. Similarly, the spouse should not be expected to draw on savings or other capital sums.

   (b) The dependent spouse should be expected to use funds provided through a monthly Board pension, Canada Pension Plan benefits, allowances from the Canada Employment and Immigration Commission, etc. to meet ordinary living expenses while completing a training program. If the spouse's income from such sources falls below the minimum weekly level determined by the Board, the Vocational Rehabilitation Consultant will normally authorize the payment of a training allowance sufficient to raise the spouse's income to the minimum. The allowance is payable to the spouse during the period required to complete the training program.

   (c) The minimum is equal to the weekly equivalent of 60% of 75% of the minimum average earnings prescribed by Section 17(3)(c) for calculating pensions payable to spouses of deceased workers. This formula is essentially the same as is set out in Section 17(3)(c) for calculating the total pension (including Canada Pension benefits) payable to an invalid spouse or spouse over 50 without children (see #55.26 and #55.31).

   (d) Whether or not a spouse's income falls below the minimum, the Vocational Rehabilitation Consultant may supplement the income of the spouse when the actual expenses incurred during the course of the program exceed what is covered by the above items.

#91.20 Vocational Services to Dependants of Deceased Workers

As long as no expenditures are involved, Section 16(3) permits the Board to provide counselling and placement services to other dependants of decease workers when the Board considers it advisable to make these services available.

CHAPTER 12

CLAIMS PROCEDURES

#92.00 INTRODUCTION

This chapter relates to the roles and responsibilities of workers, employers, physicians, and the Board in the making and adjudicating of compensation claims.

#93.00 RESPONSIBILITIES OF CLAIMANTS

#93.10 Report to Employer

Section 53(1) provides that "In every case of an injury or disabling occupational disease to a worker in an industry within the scope of this Part, the worker, or in case of death the dependant, must as soon as practicable after the occurrence inform the employer by giving information of the disease or injury to the superintendent, first aid attendant, supervisor, agent in charge of the work where the injury occurred or other appropriate representative of the employer, and the information must include the name of the worker, the time and place of the occurrence, and, in ordinary language, the nature and cause of the disease or injury."

Where the worker's condition results from a series of injuries rather than just one injury, Section 53(1) is complied with if the report to the employer is made as soon as practicable after the last injury in the series.

In the case of an occupational disease, the employer to be informed of the death or disablement is the employer who last employed the worker in the employment to the nature of which the disease was due. (1)

Where the injury or disease is suffered by a commercial fisher, the "employer" to whom the fisher must report is set out in Fishing Industry Regulation 10 (found in Workers' Compensation Reporter Decision 223).

#93.11 Procedure for Reporting

There is no requirement as to the form of the notice. It may be written or oral. However, the worker shall, if fit to do so and on request of the employer, provide to the employer particulars of the injury or occupational disease on a form prescribed by the Board and supplied by the employer. (2)

For the convenience of employers, the Board has prepared a form for the worker's report. This form, "Worker's Report of Injury or Occupational Disease to Employer", is called Form 6A. As long as the employer uses exactly this form prescribed by the Board, the worker is required by law to complete the form as long as fit to do so, and requested to do so by the employer.

There is no law which prevents an employer from using another form for the purpose of a worker's report, and including such questions as the employer may wish. But if another form is used, it must not be described as a form supplied or prescribed by the Board, and the worker is not required by law to complete it.

If the employer does not have all of the information requested on the Form 7, (3) the employer is not required to obtain it from the worker. The obligation of an employer, when completing a Form 7, is to investigate the reported injury or occupational disease and to provide the Board with the information obtained. (4)

Many employers set up their own system of reporting to assist them in carrying out their obligations. If the worker, however, reports to some other company official who was not designated by the employer, this does not mean there is no compliance with his or her responsibilities under the Act.

#93.12 *Failure to Report*

Section 53(4) provides that a "Failure to provide the information required by this section is a bar to a claim for compensation . . ., unless the board is satisfied that

(a) the information, although imperfect in some respects, is sufficient to describe the disease or injury suffered, and the occasion of it;
(b) the employer or the employer's representative had knowledge of it; or
(c) the employer has not been prejudiced, and the board considers that the interests of justice require that the claim be allowed."

The evidence may show that it was practicable for a worker to report the injury or disease to the employer long before such a report was actually made. In such a case, there will be "Failure to provide the information required by this section …" within the meaning of Section 53(1).

#93.13 *Injuries, Disablements, or Deaths Occurring Prior to August 1, 1974*

The provisions discussed in #93.10-12 apply to injuries, disablements from occupational disease and deaths occurring on or after August 1, 1974.

Similar rules operated in respect of injuries, disablements and deaths occurring prior to that date, although the wording of the statutory provisions is different. (5)

#93.20 Application for Compensation

Section 55(1) provides in part that “An application for compensation must be made on the form prescribed by the board or the regulations and must be signed by the worker or dependant . . .”

Where the Board receives a report that a worker has suffered an injury or disease which will likely cause a loss of wages, it will automatically forward a Form 6, Application for Compensation and Report of Injury or Occupational Disease. The worker should complete this form and return it to the Board. In the case of someone covered by personal optional protection, the application is made on a Form 6/7, Independent Operator’s Application for Compensation and Report of Injury, but a Form 6 may also be used.

For applications for compensation in respect of hearing loss, reference should also be made to #31.30. In the case of occupational diseases, reference should be made to #32.50 - #32.58.

#93.21 Time Allowed for Submission of Application

Section 55(2) provides that "Unless an application is filed, or an adjudication made, within one year after the date of injury, death or disablement from occupational disease, no compensation is payable, except as provided in subsections (3), (3.1), (3.2) and (3.3)." (Subsections (3) and (3.1) are discussed in #93.22.)

Where the worker's condition results from a series of injuries rather than just one injury, Section 55(2) is complied with if the application is filed within one year of the last injury in the series.

The section is not complied with simply by reporting the injury to the first aid attendant or having it confirmed by witnesses. The one-year period commences at the date of injury or death, and except in the case of occupational diseases, not at the date of subsequent disablement. In the case of occupational diseases, reference should be made to #32.50.

#93.22 Application Made Out of Time

Before an application for compensation can be considered on its merits, it must satisfy the requirements of section 55. It is important to distinguish between the decision on the merits of the claim and the decision made under section 55. Even though a Board officer may feel that a claim will, in any event, be denied on the merits, he or she must always first reach a separate decision on the effect of section 55.

Sections 55(3), (3.1), (3.2), and (3.3) provide as follows:

> "(3) If the Board is satisfied that there existed special circumstances which precluded the filing of an application within one year after the date referred to in subsection (2), the Board may pay the compensation provided by this Part if the application is filed within 3 years after that date.
>
> (3.1) The Board may pay the compensation provided by this Part for the period commencing on the date the Board received the application for compensation if
>
> (a) the Board is satisfied that special circumstances existed which precluded the filing of an application within one year after the date referred to in subsection (2), and
>
> (b) the application is filed more than 3 years after the date referred to in subsection (2).
>
> (3.2) The Board may pay the compensation provided by this Part if
>
> (a) the application arises from death or disablement due to an occupational disease,
>
> (b) sufficient medical or scientific evidence was not available on the date referred to in subsection (2) for the Board to recognize the disease as an occupational disease and this evidence became available on a later date, and
>
> (c) the application is filed within 3 years after the date sufficient medical or scientific evidence as determined by the Board became available to the Board.
>
> (3.3) Despite section 96(1), if, since July 1, 1974, the Board considered an application under the equivalent of this section in respect of death or disablement from occupational disease, the Board may reconsider that application, but the Board must apply subsection (3.2) of this section in that reconsideration.

The general effect of these provisions is that two requirements must be met before an application received outside the one year period can be considered on its merits. These are:

1. There must have existed special circumstances which precluded the application from being filed within that period, and

2. The Board must exercise its discretion to pay compensation.

The application cannot be considered on its merits if no such special circumstances existed or the Board declines to exercise its discretion in favour of the claimant. Each of these two requirements of section 55(3) must be considered separately.

1. Special Circumstances

It is not possible to define in advance all the possible situations that might be recognized as special circumstances which precluded the filing of an application. The particular circumstances of each case must be considered and a judgment made. However, it should be made clear that in determining whether special circumstances existed, the concern is solely with the claimant's reasons for not submitting an application within the one-year period. No consideration is given to whether or not the claim is otherwise a valid one. If the claimant's reason for not submitting an application in time are not sufficient to amount to special circumstances, the application is barred from consideration on the merits, notwithstanding that the evidence clearly indicates that the claimant did suffer a genuine work injury.

The following facts illustrate a situation where special circumstances were found to exist. The claimant suffered a minor right wrist injury on October 20, 1976, which at the time caused him no disablement from work and did not require him to seek medical attention. There was, therefore, no reason why he should claim compensation from the Board, nor any reason why his doctor or employer should submit reports to the Board. It was not until 1978 when the claimant began to experience problems with his right wrist that he submitted a claim to the Board. It was only then that he was incurring monetary losses for which compensation might be appropriate.

2. Discretion of the Board

Assuming the Board accepts that there were special circumstances that precluded the claimant from submitting an application within the one-year period, the second requirement of section 55(3) must then be dealt with. The question arises as to whether or not the Board should exercise its discretion to pay compensation.

Once special circumstances within the meaning of section 55(3) have been shown to exist, the Board should in general exercise its discretion under that section in favour of allowing workers' applications to be considered on their merits. However, the Board cannot automatically exercise its discretion in every case in this way without having regard to the particular facts of each claim.

The exercise of the Board's discretion depends on the extent to which the lapse of time since the injury has prejudiced the Board's ability to carry out the necessary investigations into the validity of the claim. The length of time elapsed will be a significant factor here, together with the nature of the injury. Also significant will be whether there are witnesses or other persons to whom the claimant reported the injury and from whom he sought treatment for it who are still able to provide accurate statements to the Board. The Board will not exercise its discretion under section 55(3) in favour of allowing an application to be considered where, because of the time elapsed, sufficient evidence to determine the occurrence of the injury and its relationship to the claimant's complaints cannot now be obtained.

The facts of the case discussed above illustrate a situation where, even though there were special circumstances precluding the claimant from submitting his application within the one-year period, the Board decided to exercise its discretion against allowing the claimant's application to be considered on its merits. The fact that the initial injury was a minor one which caused no immediate problems and required no medical treatment meant that it was impossible to obtain detailed evidence as to the real nature of the original injury. Furthermore, this was a case where detailed medical evidence of this nature would be particularly necessary since, on the face of it, it would be hard to relate the claimant's complaints to such a minor injury two years before.

The exercise of the Board's discretion under section 55(3) may, in some cases, appear in substance to be closely related to the question that would arise on the merits of the claim as to whether the injury in question occurred and whether it caused the claimant's subsequent complaints. If there is now an inability to obtain evidence regarding the original injury, that would normally mean that the claim would be disallowed on the merits for lack of evidence to support it. On the other hand, there will be cases where, notwithstanding the Board's exercising its discretion in

favour of allowing an application to be considered, the claim will nevertheless be disallowed on the merits. For the reason connected with the appeals system outlined at the beginning of policy item #93.22 it is always necessary, in any event, to separate the decision on the merits and the exercise of discretion under section 55(3).

Where an application for compensation received outside the one-year period is considered on its merits by virtue of section 55(3), the date of receipt of the application will be the effective date for the purpose of calculating any entitlement to interest under policy item #50.00.

EFFECTIVE DATE: March 3, 2003 (as to new wording of section 55(3.3))
APPLICATION: Not applicable.

#93.23 *Adjudication without an Application*

Where the Board is satisfied that compensation is payable, it may be paid without an application. (7)

In accordance with this provision, a Claims Adjudicator may pay all the compensation due on a claim without first receiving an application from the worker. However, the Adjudicator will not normally do this in certain types of cases, notably the following:

1. The employer is objecting to the claim.
2. The claim is doubtful.
3. A disability award may result.
4. In personal optional protection cases before wage loss is payable.
5. Where a preliminary determination under policy item #96.21 is carried out.
6. In third-party and out-of-province cases.
7. Silicosis claims.
8. On fatal claims before a pension can be paid. A decision on the acceptability of the claim and the payment of funeral and lump-sum benefits can be made without an application.

Claims are generally not paid without a worker's application form unless there is a report from the employer or other equivalent documentation and a medical report on file. Adjudicators can however exercise discretion where the circumstances warrant a deviation from this requirement.

A Claims Adjudicator will not accept a claim and pay compensation where the worker indicates that she or he does not wish to claim.

EFFECTIVE DATE: March 3, 2003 (as to reference to preliminary determination under policy item #96.21)

APPLICATION: Not applicable.

#93.24 Injuries, Occupational Diseases, and Deaths Occurring Prior to January 1, 1974

The provisions set out in subsections 55(1) to and including 55(3.3) apply to an injury or death occurring on or after January 1, 1974, and to an occupational disease in respect of which exposure to the cause of the occupational disease in the province did not terminate prior to that date. (8)

In respect of injuries, deaths and disablements by occupational diseases occurring prior to that date, the predecessor of the *Workers' Compensation Act*, 1968, C.59, S. 52, provided as follows:

> "(1) Unless an application for compensation is filed
>
> (a) within one year after the day upon which the injury or disablement by industrial disease occurred; or
>
> (b) in case the applicant is a dependent, within one year after the death,
>
> no compensation other than medical aid is payable under this Part.
>
> (2) Medical aid is payable if proof of injury is filed within one year of the occurrence of injury or disablement from industrial disease without a formal application therefor being filed by the workman.
>
> (3) The application for compensation shall be made on the form prescribed by the Board or the regulations and shall be signed by the workman or dependent.
>
> (4) Where the Board is satisfied that there existed special circumstances which precluded the filing of an application within the period set out in subsection (1), it may pay the compensation provided by this Part on receipt of proof of injury and an application

> filed by the workman within three years from the date of injury or one year from the date of commencement of the first period of temporary partial or temporary total disablement from an industrial disease, or by a dependant within three years after the death." (9)

The effect of Subsection (4) is that no compensation is payable under any circumstances where the application for compensation was, in the case of personal injury, received more than three years after the date of injury and, in the case of occupational disease, received more than one year after the first disablement from work. The Board has no general power to waive these requirements and extend the time period in which an application must be submitted beyond the period set out in Section 52(4).

For the application of this section to hearing-loss claims where the exposure to industrial noise terminated prior to January 1, 1974, reference should be made to #31.70.

#93.25 Signature on an Application for Compensation

The application for compensation must be signed by the worker. (10) Printed signatures are not acceptable, except in the case of claimants whose education has been in a different script, for example, claimants of East Indian or Chinese origin. A carbon copy of a signature is not acceptable.

An “X” in lieu of signature is acceptable if the claimant is unable to sign because of the injury or he or she is illiterate. Such a signature must be countersigned by a responsible adult. It is preferable but not mandatory that the signature should read “witnessed by” followed by the countersignor’s signature and address.

If the claimant is unconscious, has a severe head injury, is of unsound mind, or has some other condition which prevents the signing of an application, the Board may accept an application signed by someone on the claimant’s behalf. This might be a spouse, mother, father, relative, etc. If the worker is married, the person who signs should normally be the spouse. If the worker is single, it should normally be the mother or father.

Unless otherwise disabled, a worker under the age of 19 years can and should sign the application form. (11)

#93.30 Medical Treatment and Examination

The obligations of an injured worker to undertake medical treatment and examination are discussed in #78.00.

#93.40 Working While Receiving Wage-Loss Benefits

A worker is obliged to report to the Board any earnings which are received while being paid wage-loss benefits. Such earnings will be taken into account in computing wage-loss benefits under the rules discussed in #35.00

#94.00 RESPONSIBILITIES OF EMPLOYERS

#94.10 Report to the Board

Subject to #94.12-13, an employer shall report to the Board within three days of its occurrence every injury to a worker that is or is claimed to be one arising out of and in the course of employment.

Subject to #94.12-13, an employer shall report to the Board within three days of receiving information under Section 53, (12) every disabling occupational disease, or claim for or allegation of an occupational disease.

An employer shall report immediately to the Board and to its local representative the death of a worker where the death is or is claimed to be one arising out of and in the course of employment. (13)

The application of the above provisions to claims by commercial fishers is discussed in Fishing Industry Regulations 10 and 4 (found in Workers' Compensation Reporter Decisions 223 and 224).

#94.11 Form of Report

The report shall be on the form prescribed by the Board and shall state:

1. the name and address of the worker;

2. the time and place of the disease, injury, or death;

3. the nature of the injury or alleged injury;

4. the name and address of any physician or qualified practitioner who attended the worker; and

5. any other particulars required by the Board or by the regulations, and may be made by mailing copies of the form addressed to the Board at the address the Board prescribes.

The Board has prescribed forms for employers to report injuries, deaths, or occupational diseases. These are as follows:

Form 7	Employer's Report of Injury or Occupational disease
Form 7A	First Aid Report (Supplementary to Employer's Form 7. It is completed by the first aid attendant, or other person rendering first aid.)
Form 9	Employer's Subsequent Statement (Completed at the employer's option or at the Board's request, as soon as the injured worker has returned, or is able to work.)

The report must be approved by an authorized official of the employer other than the claimant.

#*94.12 What Injuries Must Be Reported*

A reportable injury is an injury arising out of and in the course of employment, or which is claimed by the worker concerned to have arisen out of and in the course of such employment, and in respect of which any one of the following conditions is present or subsequently occurs.

1. The worker loses consciousness following the injury, or

2. The worker is transported, or directed by a first aid attendant or other representative of the employer to a hospital or other place of medical treatment, or is recommended by such person to go to such place, or

3. The injury is one that obviously requires medical treatment, or

4. The worker states an intention to seek medical treatment, or

5. The worker has received medical treatment for the injury, or

6. The worker is unable or claims to be unable by reason of the injury to return to his or her usual job function on any working day subsequent to the day of injury, or

7. The injury or accident resulted or is claimed to have resulted in the breakage of an artificial member, eyeglasses, dentures, or a hearing aid, or

8. The worker or the Board has requested that an employer's report be sent to the Board.

Section 54(6) provides that ". . . the board may by regulation

(a) define and prescribe a category of minor injuries not required to be reported under this section; . . ."

Where none of the conditions listed 1 to 8 above are present, an injury is a minor injury and not required to be reported to the Board unless one of those conditions subsequently occurs.

#94.13 *Commencement of the Obligation to Report*

The obligation of the employer to report the injury to the Board commences when a supervisor, first aid attendant, or other representative of the employer first becomes aware of any one of the conditions listed in #94.12, or when notification of any such condition is received by mail or telephone at the local or head office of the employer. (14)

An employer who protests a claim should take care not to delay the submission of the Form 7 employer's report to the Board. If the employer wishes to investigate further, the employer should submit the Form 7 stating that an investigation report will follow, and give reasons for the delay.

#94.14 *Adjudication and Payment without Employers Report*

An employer is always given an adequate opportunity to submit a F7 employer's report before a claim is adjudicated in its absence. If a claim is adjudicated without a Form 7 employer's report and then, after adjudication to allow and pay the claim, the employer's report is received objecting to the acceptability of the claim, the Board officer will investigate any of the matters raised in the objection. If, following investigation the Board officer is satisfied that the claim was properly accepted, the employer will be advised of the details and informed of the relevant rights of review and/or appeal. Payments to the worker will be continued during the investigation unless there is evidence suggesting fraud. In this case, the procedure set out in policy item #96.23 may be followed. If following an investigation and within 75 days of when the decision on the claim was made, a Board officer is satisfied that on the basis of new evidence, a mistake of evidence, a policy error or a clear error of law that the claim should not have been accepted, the Board officer may reconsider the decision.

EFFECTIVE DATE: March 3, 2003 (as to references to review, appeal and reconsideration)
APPLICATION: Not applicable.

#94.15 *Penalties for Failure to Report*

Section 54(5) provides that "The failure to make a report required by virtue of this section, unless excused by the Board on the ground that the report for some sufficient reason could not have been made, constitutes an offence against this Part." The maximum fine for committing this offence is set out in Part 1 of Appendix 6.

Section 54(7) provides that "Where a report required by this section is not received by the board within 7 days of an injury or death, or any other time prescribed by regulation under . . ." #94.13, ". . . the Board may make an interim adjudication of the claim, and, where it allows the claim on an interim basis, may commence the payment of compensation in whole or in part."

Section 54(8) provides that "Any compensation paid under subsection (7), until 3 days after receipt by the Board of the report required by this section, may be levied and collected from the employer by way of additional assessment . . ., and payment may be enforced in like manner as other assessments."

Where the Board is satisfied that the delay in reporting was excusable, it may relieve the employer in whole or in part of the additional assessment imposed under subsection (8). (15)

Effective January 1, 1978, the Board established a procedure for implementing section 54(7)-(8).

At the end of each six-month period, a review is undertaken of employers who have been late in filing their reports of injury to the Board. As a result of this review, a first letter may be sent out to defaulting employers informing them of their records over the past six months and warning them of the effect of the section. At the end of the following six-month period, any employers who received the initial letter and who continue to default will receive a second letter. This will warn them that, on any future claims where an interim adjudication is made under section 54(7) accepting the claim, they will be charged with the full amount of costs incurred up to the elapse of three days from the receipt of their employer's report.

Prior to charging the cost of any particular claim to an employer under section 54(8), the Board officer will first send a letter asking if there is any reason why the employer should be excused from the penalty. Following the employer's reply or if there is no reply, the Board officer will then make a decision and notify the employer.

Set out below are some reasons why employers may be excused for late reporting. These are guidelines only, as each case must be considered individually.

1. The worker lays off some time after the day of the injury and when the days are counted from the date of lay-off to the date of the Form 7's arrival, they number fewer than ten.

2. A report is requested by the Board to start a new claim after investigation of a reopening indicates a new incident. However, the

Form 7 must be received within three days from the date the firm is notified of the new claim.

3. The worker does not report the incident to the employer until some time after the lay-off.

4. There is no wage loss involved and the employer was not aware the claimant sought medical attention.

5. The decision to accept the claim is made on the 11th day after the injury, and the Form 7 arrived at the Board, but not on file, before the 10th day.

The costs charged to the employer will consist of all health care benefits, rehabilitation, and wage-loss payments relating to the period in question, even though they are not actually paid until some time afterwards.

The employer will continue to be charged with the costs incurred on claims on which the employer is late in reporting until the overall reporting record is shown to have improved sufficiently at a subsequent six-month review.

The term “interim adjudication” used in this context should not be confused with the term “preliminary determination” when it applies to the processing of payments on an apparently acceptable claim in the absence of some information which is likely to be delayed. The latter procedure is set out in policy item #96.21. The requirements of the preliminary determination procedure do not have to be met for an interim adjudication under section 54(7). It is sufficient if the claim does appear to be an acceptable one and is only being held up by the technicality of the employer’s failure to submit a report.

When the Form 7 employer’s report does arrive, it can be considered as evidence in making the final adjudication of the claim. The rules set out in policy item #96.21 regarding the non-recovery of payments made under a preliminary determination also apply here. If the employer’s report protests the acceptance of the claim, but the final adjudication is that it remains allowed, the employer will receive the usual notification of the relevant rights of review and/or appeal.

The above procedure applies to pay employer claims (16) and to employers with deposit accounts, but not to personal optional protection or Federal Government claims.

Unless the Board receives the Form 7 employer’s report, the interim adjudication becomes the final decision on the acceptability of the claim and is subject to the provisions of section 96(5) of the *Act*.

If the Board receives the Form 7 employer's report, the final adjudication becomes the final decision on the acceptability of the claim and is subject to the provisions of section 96(5) of the *Act*.

The final adjudication does not constitute a reconsideration of the interim adjudication for purposes of section 96(4) and (5). Section 54(7) contemplates that a final adjudication will be made, whenever the Form 7 employer's report is received.

EFFECTIVE DATE: March 3, 2003 (as to references to preliminary determination and the status of final adjudication for the purposes of section 96(4) and (5))

APPLICATION: Not applicable.

#94.20 Employer or Supervisor Must Not Attempt to Prevent Reporting

Section 177 of the Workers Compensation Act provides as follows:

> An employer or supervisor must not, by agreement, threat, promise, inducement, persuasion or any other means, seek to discourage, impede or dissuade a worker of the employer, or a dependant of the worker, from reporting to the board
>
> (a) an injury or allegation of injury, whether or not the injury occurred or is compensable under Part 1,
> (b) an illness, whether or not the illness exists or is an occupational disease compensable under Part 1,
> (c) a death, whether or not the death is compensable under Part 1, or
> (d) a hazardous condition or allegation of hazardous condition in any work to which this Part applies.

The Board may impose an administrative penalty if it is determined that an employer has violated Section 177. The general criteria for calculating administrative penalties are provided in the *Prevention Manual* at item D12-196-6. The "basic amount" of the administrative penalty will normally be determined in accordance with the amounts established for a "Category B Penalty". Where the non-compliance was willful or with reckless disregard, the penalty may be determined in accordance with the amounts established for a "Category A Penalty".

Policy item D12-196-6 also provides for the recovery of costs saved through non-compliance. The amount of any costs saved or profit made by the employer through committing the violation shall, as far as known, be added to the penalty amount.

As an alternative to imposing an administrative penalty, the Board may refer the case to Crown Counsel for consideration of prosecution. The maximum fine that may be levied following conviction is set out in Part 2 of Appendix 6.

#95.00 RESPONSIBILITIES OF PHYSICIANS/QUALIFIED PRACTITIONERS

It is the duty of every physician or qualified practitioner (17) attending or consulted on a case of injury to a worker, or alleged case of injury to a worker, in any industry within the scope of Part 1 of the Act to furnish reports in respect of the injury in the form required by the regulations or by the Board.

The first report containing all information requested in it shall be furnished to the Board within three days after the date of the physician's or qualified practitioner's first attendance upon the worker.

If treatment continues, progress reports must be provided.

The physician or qualified practitioner must furnish a report within three days after the worker is, in the opinion of the physician or qualified practitioner, able to resume work and, if treatment is being continued after resumption of work, furnish further adequate reports. (18)

#95.10 Form of Reports

The Board has prescribed forms for each type of report, the most common of which are as follows:

Form 8	Physician's First Report
Form 11	Physician's Progress Report
Form 11A	Physician's Report and Account

Similar forms are provided for qualified practitioners and other persons authorized to treat workers under the Act.

All medical reports must be signed by the person making the report. A rubber stamp should also be used to denote the professional designation of a partnership or a clinic. The original report, not the carbon copy, should be mailed to the Board. Any change in status of a partnership or clinic, or change in its address, should be reported in writing to the Board without delay to assure proper direction of payment.

#95.20 Reports by Specialist

If the physician is a specialist whose opinion is requested by the attending physician, the worker, or the Board, or if he or she continues to treat the worker after being consulted as a specialist, a first report must be furnished to the Board within three days after completion of the consultation; but if the specialist is regularly treating the worker, the specialist shall submit reports as required in #95.00. (19)

Section 1 defines a "specialist" as ". . . a physician residing and practising in the Province and listed by the Royal College of Physicians and Surgeons of Canada as having specialist qualifications."

#95.30 Failure to Report

Physicians, qualified practitioners, or other persons who fail to submit prompt, adequate and accurate reports and accounts as required by the Act or the Board commit an offence, and their right to be selected by a worker to render health care may be cancelled by the Board, or they may be suspended for a period to be determined by the Board. When the right of a person to render health care is so cancelled or suspended, the Board shall notify the person of the cancellation or suspension, and shall likewise inform the governing body named in the Act under which the person is authorized to treat human ailments, and the person whose right to render health care is cancelled or suspended shall also notify any injured workers who seek treatment from him or her of the cancellation or suspension. (20)

The maximum fine for the offence committed under the Act is set out in Part 1 of Appendix 6.

The Board may refuse to pay accounts where reports are inadequate.

#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 "Subject to sections 239 and 240, 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 may not be maintained or brought against the Board or a director, an officer or an employee of the Board in respect of any act, omission or decision that was within the jurisdiction of the Board or that the Board, director, officer or employee believed 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."

EFFECTIVE DATE: March 3, 2003 (as to new wording of section 96(1))
APPLICATION: Not applicable.

#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.

EFFECTIVE DATE: February 11, 2003 (as to references to Board of Directors policies)
March 3, 2003 (as to deletion of references to how policy is to be applied)

APPLICATION: Not applicable.

#96.20 Board Officers

For all decisions, including appellate decisions, made on or after July 2, 2004, please refer to policy item #96.20, *Board Officers,* in Volume II of the *RS&CM.*

A Board officer 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 Board officer determines the amount and duration of compensation to be paid for temporary disability.

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

The term "compensation" includes, among other things, health care benefits, transportation and subsistence.

It is the responsibility of Board 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 Board 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. Board 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 Board officer to clearly delineate by memo the status of the claim and to confirm what conditions have been accepted.

EFFECTIVE DATE:	July 2, 2004
APPLICATION:	For all decisions, including appellate decisions, made on or after July 2, 2004, please refer to policy item #96.20, *Board Officers,* in Volume II of the *RS&CM.*
HISTORY:	March 3, 2003 - deletion of statements regarding the return of receipts for particular items that do not qualify for payment on a claim, and housekeeping changes.

#96.21 *Preliminary Determinations*

A preliminary determination on a claim will be made, to provide temporary financial relief to the worker until the Board receives the information necessary to make a decision on the validity of the claim, when the following conditions are present:

1. The worker appears to be currently disabled from work.

2. On the available evidence, it appears probable that the worker is suffering from a compensable injury or occupational disease, or at least it appears that the evidence is evenly weighted.

3. There is some significant delay in obtaining evidence necessary to arrive at a conclusion on the validity of the claim, and the Board officer 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 the worker. 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)

7. An application for compensation has been received.

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

When a preliminary determination is made, the following rules will apply:

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

2. Payments of wage-loss benefits under the preliminary determination will commence as of the date when the Board officer makes the determination. Arrears of wage-loss benefits for any time period prior to that date will not be paid until a decision on the validity of the claim is made, except that the Board officer may pay such arrears on a preliminary determination to the extent that this may be necessary to avoid hardship.

3. The Board officer will proceed to obtain the evidence necessary to reach a decision on the claim as soon as possible.

4. Health care benefit bills will not be paid under a preliminary determination. Where a preliminary determination has been made on a claim 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 decision on the claim. This principle also applies with respect to other medical referrals, with the exception of a consultation with a specialist that may be paid on an investigation basis.

5. Where a preliminary determination has been made on a claim and wage loss payments have commenced, and subsequently a decision is made to disallow the claim, then:

   (a) no recovery of the payments will be made in the absence of fraud or misrepresentation;

   (b) the employer's sector or rate group will be relieved of the cost of any unrecovered payments pursuant to policy item #113.10.

The above rules governing preliminary determinations apply to applications to reopen a previous claim as well as applications commencing new claims.

A preliminary determination made in accordance with this policy is not a "decision" for the purposes of section 96(5). Rather, it is a Board administrative action that is intended to provide temporary financial relief to the worker until the Board receives the information required in order to make a decision on the validity of the claim. However, once the Board receives the required information and makes a decision, that decision is subject to the provisions of section 96(5).

EFFECTIVE DATE: March 3, 2003
APPLICATION: To all preliminary determinations made on or after the effective date.

#96.22 *Suspension of Claim*

Where a report is submitted to the Board simply for the record, and where the worker did not receive medical treatment or was not disabled from work, or no other costs were incurred, no adjudication is necessary and the claim will be accepted for information purposes only.

Where information necessary to the adjudication of a claim can only be provided by the worker, and the worker ignores a request for that information, refuses to provide it or hampers the investigation, the claim may be suspended.

Where a claim is opened, and it is later established that the claim will be fully administered and paid by another Board under the terms of the Interjurisdictional Agreement, the British Columbia claim will be placed in suspense. (24)

Wage-loss benefits may also be suspended in the following situations:

1. where the claimant leaves the province without notifying the Board or receiving prior consent from the Board; (25)

2. where the claimant is being paid full salary by the Federal Government; (26)

3. where the claimant refuses to accept the cheques;

4. where a worker moves and the worker's whereabouts are unknown.

Where a claim has been suspended, all parties are notified of this fact and of the reasons for it. This includes any party from whom an account has been received. When the information required has been received or any other ground which gave rise to the suspension has been removed, the suspension will be lifted. In that event, the parties involved will again be notified.

#96.23 *Withholding Wage-loss Benefits Pending Investigation*

Once the Board has made an initial decision to accept a claim and pay wage-loss benefits, these benefits are usually paid on a regular basis for as long as the Board continues to receive medical reports showing disability. Furthermore, benefits will not be suspended simply because of a lack of medical reports. Although it is the responsibility of the worker to seek required medical attention so that the necessary ongoing proof of disability can be submitted by her or his doctor, it is not the responsibility of the worker to procure these reports. While the worker's assistance is often requested, the final responsibility for obtaining the reports rests with the Board.

The Board will use its best efforts to obtain necessary reports and carry out investigations as quickly as possible so that there is no delay in the payment of benefits. However, it may be that in some cases there will be delays where the necessary investigations cannot be carried out in time. The Board must be

satisfied before it makes any payment of wage loss that the requirements of the Act are met and may withhold benefits temporarily until it is able to satisfy itself of this. Even if there are medical reports on file indicating that the claimant is disabled, there may be other information indicating that this is not the case, for example, that he or she is working, which may require that benefits be withheld pending investigation. The highest priority is given to investigations which are causing a delay in benefits. The claimant is notified of any significant delays because of the need to carry out investigation.

#96.30 Disability Awards Officers and Adjudicators in Disability Awards

For all decisions, including appellate decisions, made on or after July 2, 2004, please refer to policy item #96.30, *Board Officers in Disability Awards,* in Volume II of the *RS&CM.*

Disability Awards Officers and Adjudicators in Disability Awards determine whether a worker's injury or occupational disease has caused a permanent disability. They then decide the extent of the disability and calculate the worker's pension entitlement. Disability Awards Officers and Adjudicators in Disability Awards must accept the final decision of the Claims Adjudicator as to what conditions are accepted under the claim. The Claims Adjudicator is required to outline the decision in a memo when referring the claim to the Disability Awards Officer or Adjudicator in Disability Awards.

In cases of minor disabilities, the Disability Awards Officer or Adjudicator in Disability Awards may calculate the award without the benefit of a medical examination if this is considered unnecessary having regard to the medical evidence already on the claim. Except for those cases, the normal practice is for a permanent functional impairment evaluation to be conducted for disability awards purposes by a Disability Awards Medical Advisor or an authorized External Service Provider (see *Item #38.10*).

Although the evaluation is not the only medical evidence that the Disability Awards Officer or Adjudicator in Disability Awards may use, it will usually be the primary input.

The decision-making procedure for assessing entitlement to a permanent disability award for psychological impairment is discussed in #38.10

There may be cases where the Disability Awards Officer or Adjudicator in Disability Awards will be able to conclude from the information on the claim that there is no compensable permanent disability resulting from the injury.

Where, after reviewing a claim, the Disability Awards Officer or Adjudicator in Disability Awards decides there is no permanent disability, it is not necessary to inform the worker of this conclusion unless it is evident the worker has enquired about entitlement or expressed some expectations of receiving an award. The

above process is considered an extension of the referral initiated by the Claims Adjudicator or Claims Officer.

There are also borderline situations where the Disability Awards Officer or Adjudicator in Disability Awards may seek advice or clarification from the Disability Awards Medical Advisor concerning the question of potential disability. If, after this process, the Disability Awards Officer or Adjudicator in Disability Awards concludes that no disability is evident, it is not necessary to advise the worker of this conclusion, unless there has been a specific enquiry or it is evident that the worker has expectations of receiving an award.

However, in those cases where the worker has a permanent functional impairment evaluation, the Disability Awards Officer or Adjudicator in Disability Awards is required to notify the worker indicating the results of the evaluation and the conclusions reached regarding the question of pension entitlement.

The final decision on the assessment of a pension on a projected loss of earnings basis is made by the Disability Awards Committee which consists of one senior representative from the Disability Awards, Medical, and Vocational Rehabilitation Services Departments.

Requests for the commutation of pensions are adjudicated in the first instance by Adjudicators in Disability Awards. Before making a decision, they may ask the Rehabilitation Consultant to contact the claimant and obtain the necessary information.

EFFECTIVE DATE: July 2, 2004
APPLICATION: For all decisions, including appellate decisions, made on or after July 2, 2004, please refer to policy item #96.30, *Board Officers in Disability Awards,* in Volume II of the *RS&CM.*

#97.00 EVIDENCE

Under the old English system, which was an adversary system of workers' compensation, there was a burden of proof imposed on the worker, but that is not the correct practice here. The Claims Adjudicator must not start with any presumption against the worker, but neither must there be any presumption in the worker's favour. The correct approach is to examine the evidence to see whether it is sufficiently complete and reliable to arrive at a sound conclusion with confidence. If not, the Adjudicator should consider what other evidence might be obtained, and must take the initiative in seeking further evidence. After that has been done, if, on weighing the available evidence, there is then a preponderance in favour of one view over the other, that is the conclusion that must be reached. But if it appears upon the weighing of the evidence that the disputed possibilities are evenly balanced then the rule comes into play which requires that the issue be resolved in accordance with that possibility which is favourable to the worker.

Although there is no burden of proof on the claimant, the Act contains prerequisites for benefits. Compensation will not be paid simply because, for example, a telephone call is received from someone claiming to be a worker, who has been hurt, and was disabled for a certain number of days. Some basic evidence must be submitted by the worker to show that there is a proper claim. The extent of that basic evidence necessary, and the weight to be attached to it, is entirely in the hands of the Adjudicator.

It is therefore not uncommon to see that a claim will be denied when a claimant, away from employment, begins to feel some pain and discomfort in the lower back, and seeking to find a reason for this condition, thinks back to the work being done over a period of time and concludes that the problem must have resulted from something which occurred on a certain day when certain heavy work was being performed. The question then arises whether there was anything other than the claimant's hindsight which would allow the Adjudicator to conclude that the work done some weeks or months previously had causative significance. It is at this point that investigation takes place and the evidence is weighed. If there is nothing objective to indicate any activity at work was potentially causative of the condition complained of, at or near the time alleged by the claimant, it can fairly be said that the claim has not been established. The claimant has simply failed to present those fundamental facts which bring the provisions of the Act into play.

#97.10 Evidence Evenly Weighted

Complaints are sometimes received at the Board that a worker has not been given the benefit of the doubt. Usually, these complaints relate to a situation in which the claimant has a disability, but the issue is whether it is one arising out of or in the course of employment. The essence of the complaint is often that if there is some possibility that the injury arose out of the employment, the worker should be given the benefit of the doubt. For the Board to take that view, however, would be inconsistent with the terms of the *Act*. Where it appears from the evidence that two conclusions are possible, but that one is more likely than the other, the Board must decide the matter in accordance with that possibility that is more likely.

Under the terms of section 99(3), the Board is required to decide an issue in accordance with the possibility which is favourable to the worker where it appears that "the evidence supporting different findings on an issue is evenly weighted in that case". This applies only where there is evidence of roughly equal weight for and against the claim. It does not come into play where the evidence indicates that one possibility is more likely than the other. (27)

While an absence of positive data does not necessarily mean that a condition is not related to a person's employment, it may mean that there is a lack of evidence that any such relationship exists. The Board, as a quasi-judicial body,

must make its decisions according to the evidence or lack of evidence received, not in accordance with speculations unsupported by evidence. Section 99(3) of the *Act* applies when "the evidence supporting different findings on an issue is evenly weighted in that case." However, if the Board has no evidence before it that a particular condition can result from a worker's employment, there is no doubt on the issue; the Board's only possible decision is to deny the claim. If one speculates as to the cause of a condition of unknown origin, one might attribute it to the person's work or to any other cause, and one speculated cause is no doubt just as tenable as any other. However, the Board can only be concerned with possibilities for which there is evidential support and only when the evidence is evenly weighted does section 99(3) apply.

EFFECTIVE DATE: March 3, 2003 (as to new wording of section 99)
APPLICATION: Not applicable.

#97.20 Presumptions

There are three statutory presumptions in favour of workers or dependants which have already been discussed in earlier chapters. These are as follows:

1. In cases where the injury is caused by accident, where the accident arose out of the employment, unless the contrary is shown, it shall be presumed that it occurred in the course of the employment; and where the accident occurred in the course of the employment, unless the contrary is shown, it shall be presumed that it arose out of the employment. (28)

2. If the worker at or immediately before the date of disablement was employed in a process or industry mentioned in the second column of Schedule B, and the disease contracted is the disease in the first column of the schedule set opposite to the description of the process, the disease shall be deemed to have been due to the nature of that employment unless the contrary is proved. (29)

3. Where a deceased worker was, at the date of death, under the age of 70 years and suffering from an occupational disease of a type that impairs the capacity or function of the lungs, and where the death was caused by some ailment or impairment of the lungs or heart of non-traumatic origin, it shall be conclusively presumed that the death resulted from the occupational disease. (30)

The Act contains no general presumption either in favour of the worker or against the claim.

#97.30 Medical Evidence

It is the responsibility of the Claims Adjudicator or Claims Officer to make all the decisions relating to the validity of a claim, and the responsibility of the Claims Adjudicator or Claims Officer, the Disability Awards Officer or Adjudicator in Disability Awards, to make all the decisions relating to compensation payments. This includes decisions relating to medical as well as other aspects of the claim.

This does not mean, of course, that a lay judgment is preferred to a medical opinion on a question of medical expertise. What it means is that the Claims Adjudicator or Claims Officer, the Disability Awards Officer or Adjudicator in Disability Awards are responsible for the decision-making process, and for reaching the conclusions on the claim. But this will, of course, require an input of medical evidence, or sometimes other expert advice, on any issue requiring professional expertise.

In reaching conclusions on a medical question, the guide-rules are set out below.

#97.31 Matter Requiring Medical Expertise

Where the matter is one requiring medical expertise, the decision must be preceded by a consideration of medical evidence (this term includes medical opinion or advice). Medical evidence might consist of a statement in the Form 8 Physician's First Report, (31) or some information or opinion from the attending physician, or it might consist of advice from a Board Medical Advisor or another doctor. It is for the Claims Adjudicator or Claims Officer to decide when medical evidence is needed, what kind of medical evidence is needed, and on what questions.

#97.32 Statement of Claimant about His or Her Own Condition

A statement of a claimant about his or her own condition is evidence insofar as it relates to matters that would be within the claimant's knowledge, and it should not be rejected simply by reference to an assumption that it must be biased. Also, there is no requirement that the statement of a claimant about his or her own condition must be corroborated. The absence of corroboration is, however, a ground for considering whether the claimant should be interviewed by the Claims Adjudicator or Claims Officer, or telephone enquiries made, or whether anything relevant could be discovered by having the claimant examined by a Board Medical Advisor. A conclusion against the statement of the claimant about his or her own condition may be reached if the conclusion rests on a substantial foundation, such as clinical findings, other medical or non-medical evidence, or serious weakness demonstrated by questioning the claimant, or if the statement of the claimant relates to a matter that could not possibly be within his or her knowledge.

#97.33 Statement by Lay Witness on Medical Question

A statement by a lay witness on a medical question may be considered as evidence if it relates to matters recognizable by a layperson; but not if it relates to matters that can only be determined by expertise in medical science. For example, a statement by a fellow worker that he or she saw the claimant suffering from silicosis would be worthless; but a statement by a fellow worker reporting to have seen the claimant bleeding from the forehead would be evidence of a head wound. Statements made by a first aid attendant or other categories of paramedical personnel can be considered insofar as they relate to matters within the normal experience or training of that category of paramedical personnel. But they must obviously be treated very cautiously if they go beyond that into areas requiring greater medical expertise, or if they conflict with the opinion of a doctor.

#97.34 Conflict of Medical Opinion

Where there are differences of opinion among doctors, or other conflicts of medical evidence, the Board officer must select among them as best she or he can. The Board officer must not do it by automatically preferring the opinions of one category of doctors to another category, nor should it be done by counting heads, so many opinions one way and so many another. The Board officer must analyze the opinions and conflicts as best as possible on each issue and arrive at her or his own conclusions about where the preponderance of the evidence lies. If it is concluded that there is doubt on any issue, and that the evidence supporting different findings on an issue is evenly weighted in that case, the Board officer must follow the mandate of section 99 and resolve that issue in a manner that favours the worker. (32)

It should never be assumed that there is a conflict of medical opinion simply because the opinions of different doctors indicate different conclusions. A difference in conclusion between doctors may or may not result from a difference in medical opinion. For example, the difference could result from different assumptions of non-medical fact. Where there are two or more medical reports or memos on file from physicians, indicating different conclusions, the Board officer will not simply select among them as a first step. The Board officer should first think about why they are different and consider whether the relevant non-medical facts have been clearly established. The Board officer will seek advice from a Board Medical Advisor to determine whether the best medical evidence has been obtained and, for example, find out if any appropriate medical procedures can be instituted that would assist in arriving at a more definite conclusion.

Where two or more medical reports or memos indicate a probable difference of medical opinion and the issue is serious, the matter will normally be discussed with the physicians involved.

The Board has no rule that states that the evidence of a physician is always to be preferred to that of a chiropractor or other qualified practitioner. Reports from both types of practitioner are acceptable evidence and are weighed on their merits. This principle applies even if the referral to the practitioner is contrary to Board policy. Should there, for example, be concurrent treatment by a physician and a chiropractor, the Board might not pay for the chiropractor, but any chiropractor reports received must be weighed as evidence. They are not ignored just because the referral was unauthorized. (33)

EFFECTIVE DATE: March 3, 2003 (as to new wording of section 99)
APPLICATION: Not applicable.

#97.35 Termination of Benefits

Where a treating physician expresses an opinion that a claimant is disabled from work by reason of a compensable disability, the Claims Adjudicator or Claims Officer may rely upon overall existing medical evidence from a doctor who has examined the worker or other substantive evidence on the file to reach a conclusion contrary to that opinion or may decide to carry out further investigation which may involve an examination by a Board physician.

#97.40 Disability Awards

In cases of very minor disabilities, Board officers in Disability Awards may proceed to calculate a disability award without a permanent functional impairment evaluation, if they consider that this is unnecessary having regard to the medical evidence already available. Except for those cases, the normal practice is for a permanent functional impairment evaluation to be conducted for disability awards purposes by a Disability Awards Medical Advisor or an External Service Provider.

It is the responsibility of the Board officer in Disability Awards to classify the disability as a percentage of total disability. In doing this, it is proper for the Board officer to consider other factual and medical evidence as well as the report of the Disability Awards Medical Advisor or the External Service Provider. However, although the report of the Disability Awards Medical Advisor or the External Service Provider is not the only medical input that a Board officer may use, it will usually be the primary input, and caution will be used in referring to any other medical opinion.

The report of a Disability Awards Medical Advisor or External Service Provider takes the form of expert evidence which, in the absence of other expert evidence to the contrary, should not be disregarded. This does not mean that a Board officer must adopt the percentage indicated by the Disability Awards Medical Advisor or External Service Provider. It is always open to the Board officer to

conclude that, although the functional impairment of the worker is a certain percentage, the disability (i.e. the extent to which that impairment affects the worker's ability to earn a living) is greater or less than the percentage of impairment.

The decision-making procedure for assessing entitlement to a permanent disability award for psychological impairment under section 23(1) of the *Act* is discussed in policy item #38.10.

In making a determination under section 23(1), the Board officer in Disability Awards will enquire carefully into all of the circumstances of a worker's condition resulting from a compensable injury.

EFFECTIVE DATE: January 1, 2003
APPLICATION: Applies to new claims received and all active claims that are currently awaiting an initial adjudication.

#97.50 Rumours and Hearsay

Hearsay must only be used very cautiously as evidence, and rumour must not be used as evidence at all. But even rumour is often valuable as a lead to investigation.

#97.60 Lies

A lie may be ground for drawing an adverse inference with regard to the facts to which it relates. But it is not in itself ground for denying compensation, particularly when it relates to something not relevant to the claim at all.

#98.00 INVESTIGATION OF CLAIMS

In the majority of claims the issues are decided by reference to the information received in the worker's application and the employer's and medical reports. Any insufficiency in the information is usually made good by telephone, correspondence, or by informal interview. In a minority of claims, a more formal inquiry, or medical examination, may be necessary.

#98.10 Powers of the Board

Section 87 of the *Act* provides as follows:

> "(1) The Board has the like powers as the Supreme Court to compel the attendance of witnesses and examine them under oath, and to compel the production and inspection of books, papers, documents and things.

(2) The Board may cause depositions of witnesses residing in or out of the Province to be taken before a person appointed by the Board in a similar manner to that prescribed by the Rules of the Supreme Court for the taking of like depositions in that court before a commissioner."

Usually, the Board receives the willing cooperation of all concerned, and the power of subpoena is not used as a normal routine.

EFFECTIVE DATE: March 3, 2003 (as to new wording of section 87)
APPLICATION: Not applicable.

#98.11 Powers of Officers of the Board

Section 88(1) provides that "The Board may act on the report of any of its officers, and any inquiry which it is considered necessary to make may be made by an officer of the Board or some other person appointed to make the inquiry, and the Board may act on his or her report as to the result of the inquiry."

The officer and every other person appointed to make an inquiry has for the purposes of an inquiry under subsection (1) all the powers conferred upon the Board by section 87. (34)

Every officer or person authorized by the Board to make examination or inquiry under this section may require and take affidavits, affirmations or declarations as to any matter of the examination or inquiry, and take affidavits for the purposes of this *Act*, and in all those cases to administer oaths, affirmations, and declarations and certify that they were made. (35)

The Board has ruled that, for the purpose of section 88, employees of the Board, who, in the performance of their prescribed duties, do those things which are reserved to be done by an officer of the Board, are, and have been, for matters arising out of Part 1 of the *Act*, appointed officers of the Board.

EFFECTIVE DATE: March 3, 2003 (as to new wording of section 88)
APPLICATION: Not applicable.

#98.12 Examination of Books and Accounts of Employer

Section 88(3) provides that "The board, an officer of the board or a person authorized by it for that purpose, may examine the books and accounts of every employer and make any other inquiry the board considers necessary to ascertain . . . whether an industry or person is within the scope of this Part. For the purpose of the examination or inquiry, the board or person authorized to make the examination or inquiry may give to the employer or the employer's agent notice in writing requiring the employer to bring or produce before the board or person, at a place and time to be mentioned in the notice, which time must be at least 10 days after the giving of the notice, all documents, writings, books, deeds

and papers in the possession, custody or power of the employer touching or in any way relating to or concerning the subject matter of the examination or inquiry referred to in the notice, and every employer and every agent of the employer named in and served with the notice must produce at the time and place required all documents, writings, books, deeds and papers according to the tenor of the notice."

An employer and every other person who obstructs or hinders the making of an examination or inquiry mentioned in Subsection (3), or who refuses to permit it to be made, or who neglects or refuses to produce the documents, writings, books, deeds, and papers at the place and time stated in the notice mentioned in Subsection (3), commits an offence. (36) The maximum fine for committing this offence is set out in Part 1 of Appendix 6.

#*98.13 Medical Examinations and Opinions*

The authority of the Board to require a worker to be medically examined is dealt with in policy item #78.20.

The medical resources of the Board cannot be used to provide a medical opinion to anyone on request. A Board Medical Advisor will, therefore, decline to provide a medical opinion if the request does not come from someone authorized to make the request. Those authorized are officers of the Board responsible for claims decisions and other Board staff where duties require an input of medical advice. Advice to treating doctors may, however, be provided according to the judgment of the Board Medical Advisor.

A Workers' Adviser and an Employers' Adviser have access to medical opinions already on file, but have no right to require any further medical opinions to be produced.

EFFECTIVE DATE: March 3, 2003 (as to deletion of references to Review Board and Appeal Division)
APPLICATION: Not applicable.

#98.20 Conduct of Inquiries

The Board operates on an inquiry as opposed to an adversary system. It does not, like a court operating under the adversary system, decide between the arguments and evidence submitted by two opposing parties at a hearing and limit itself to the material presented at that hearing. While the judge under the adversary system has little or no authority to carry out investigations, the Board is obliged by Section 96 of the Act both to investigate and to adjudicate claims for compensation. Oral hearings or interviews are not always conducted before a decision is reached and, when they are conducted, provide only part of the

information relied on by the Board. The other written reports on the file will also be considered. Such hearings are informal in nature and not subject to the formal rules of evidence and procedure followed in court hearings.

#98.21 *Place of Inquiry*

For the purposes of claims adjudication, an Adjudicator may enter premises and make such inspections as considered necessary, notwithstanding that another agency may have inspection jurisdiction for accident prevention purposes. Where an inspection is of a technical nature and can only be carried out by someone technically qualified, perhaps an Occupational Hygiene Officer, such technical personnel may be used to make an inspection for the purposes of claims adjudication.

Where a Claims Adjudicator visits the work place to investigate a claim, the claimant, where possible, should be offered the opportunity to accompany the Adjudicator.

#98.22 *Failure of Worker to Appear*

If the worker fails or refuses to appear at an inquiry, her or his claim may be suspended, or decided in her or his absence, or a further appointment may be arranged.

#98.23 *Representation*

A claimant has a right to bring a representative to any enquiry, both at first instance and on appeal.

If the claimant is unable to communicate effectively in English, an interpreter is arranged.

#98.24 *Presence of Employer*

If a claimant is unrepresented, and the employer or employer's representative appears, it must be determined whether the employer is appearing on behalf of the claimant. If the employer is appearing on behalf of the claimant, the claimant will be asked (but not in the presence of the employer) whether he or she has any objection to the employer being present. If there is no objection, the employer can be invited to attend the interview. If the claimant does object, the employer will be asked to wait outside, and can be interviewed separately.

If appearing against the claimant, the employer is not allowed to be present at the interview with the claimant and must be interviewed separately. If there is any doubt as to the employer's intentions, the employer will be interviewed separately.

If a claimant is represented, an employer may be permitted to be present even if the employer is appearing against the claimant.

#98.25 *Oaths*

The oath is not administered as a normal routine in every inquiry, but is used when considered appropriate.

If:

1. a person called to give evidence objects to taking an oath, or is objected to as incompetent to take an oath, and the Board is satisfied of the sincerity of the objection of the witness from conscientious motives to be sworn or that the taking of an oath would have no binding effect on his or her conscience; or

2. the Board is satisfied that the form of oath which a person called to give evidence declares to have a binding effect on his or her conscience is not such that it can be taken in the place where the inquiry is being held, or that it is not fitting so to do, and the Board so directs,

3. the person shall, instead of taking an oath, make an affirmation. (37) An employer or representative or a claimant's representative need not be placed under oath unless they have something specific or pertinent to contribute to the inquiry.

#98.26 *Witnesses and Other Evidence*

A claimant may bring to an inquiry such witnesses, and may submit such verbal and documentary evidence, as she or he thinks will be of assistance.

Wherever possible, witnesses will be interviewed separately without the claimant being present. They will not be present while the claimant is being interviewed.

#98.27 *Cross-examination*

Under the inquiry system (contrary to the adversary system), there is no right of cross-examination of the parties or witnesses. If, in the process of an inquiry, one of the parties wishes to ask a question of the person whose evidence is being taken, the question should be referred to the interviewer conducting the inquiry who, in turn, can relay the question if it is felt it would be helpful.

Cross-examination may, however, sometimes be permitted.

#99.00 DISCLOSURE OF INFORMATION

The Workers' Compensation Board, for the purposes of administering the *Act*, collects and maintains information for the purpose of adjudication and managing claims for workers or their dependants. In order to carry out all aspects of this activity, the Board in a variety of situations discloses information contained in claim files.

Provincial legislation, known as *Freedom of Information and Protection of Privacy Act ("FIPPA")* provides access for the public to the information maintained by the Board while at the same time protecting personal privacy.

FIPPA differentiates among "personal information", information relating to third party business interests and other types of information in the possession of a public body such as the Board. Personal information means recorded information about an identifiable individual.

Freedom of information and protection of privacy can be competing principles in many situations. Which principle is to be paramount in any particular case is sometimes difficult to determine. Until advised otherwise by the Information and Privacy Commissioner appointed under section 37 of *FIPPA*, openness prevails as far as possible in the area of compensation services. Exceptions to access should be narrowly construed. Since claim files deal with an identifiable individual, they sometimes contain personal and sensitive information. The privacy provisions of *FIPPA* will, therefore, prevail other than for the specific exceptions contained in *FIPPA*. Examples of such exceptions include the rights in section 3(2) of a party to a proceeding to access information, or the variety of exceptions listed in section 33 such as the need to comply with the requirements of a specific Act. The *Act* requires a copy of records related to a matter under review or appeal to be provided to the parties to a review or appeal.

Section 3(2) of *FIPPA* states that the *Act* does not limit the information available by law to a party to a proceeding. A proceeding does not take place until either the worker or the employer has initiated a formal review or appeal.

Before a review or appeal is initiated, the WCB must apply *FIPPA* to requests for claim information. A request by a worker should be directed to a Manager in the appropriate Service Delivery Location. The Manager will comply with the request in accordance with the *FIPPA* rules. Before a review or appeal is initiated, an employer is not entitled to a copy of the worker's claim file. Disclosure to an employer in such circumstances, is limited to that information necessary for the adjudication or administration of the claim, that is on a "need to know" basis. Once a review or appeal has been initiated, full disclosure is available to either a worker or an employer. These disclosure rules are considered to be in accordance with *FIPPA* and the rules of natural justice.

Requests for disclosure for information in a situation not covered by the policies in this Manual should be directed to the FIPP Department of the Board. These requests will be considered on an individual basis in accordance with *FIPPA.*

Dispute Resolution

A request for a review of the FIPP Department's decision by the Information and Privacy Commissioner may be made within 30 days of the date the person asking for the review is notified of the latest decision.

The Chairman, as the head of the W.C.B., has ultimate responsibility within the Board for implementation of *FIPPA* for the purposes of workers' compensation.

RELEVANT SECTIONS OF *FIPPA* HAVE BEEN REPRODUCED BELOW FOR THE CONVENIENCE OF THOSE USING THIS MANUAL.

Section 3 Scope of this Act

(2) This Act does not limit the information available by law to a party to a proceeding.

Section 9 How access will be given

(3) If the applicant has asked to examine the record under section 5(2) or if the record cannot reasonably be reproduced, the applicant must

(a) be permitted to examine the record or part of the record, or

(b) be given access in accordance with the regulations.

Section 15 Disclosure harmful to law enforcement

(1) The head of a public body may refuse to disclose information to an applicant if the disclosure could reasonably be expected to

(a) harm a law enforcement matter,

(c) harm the effectiveness of investigative techniques and procedures currently used, or likely to be used, in law enforcement,

(d) reveal the identity of a confidential source of law enforcement information,

(f) endanger the life or physical safety of a law enforcement officer or any other person,

(g) reveal any information relating to or used in the exercise of prosecutorial discretion,

(k) facilitate the commission of an offence under an enactment of British Columbia or Canada, or

(l) harm the security of any property or system, including a building, a vehicle, a computer system or a communications system.

Section 19 Disclosure harmful to individual or public safety

(1) The head of a public body may refuse to disclose to an applicant information, including personal information about the applicant, if the disclosure could reasonably be expected to

(a) threaten anyone else's safety or mental or physical health, or

(b) interfere with public safety.

(2) The head of a public body may refuse to disclose to an applicant personal information about the applicant if the disclosure could reasonably be expected to result in immediate and grave harm to the applicant's safety or mental or physical health.

Section 22 Disclosure harmful to personal privacy

(1) The head of a public body must refuse to disclose personal information to an applicant if the disclosure would be an unreasonable invasion of a third party's personal privacy.

(2) In determining under subsection (1) or (3) whether a disclosure of personal information constitutes an unreasonable invasion of a third party's personal privacy, the head of a public body must consider all the relevant circumstances, including whether

(c) the personal information is relevant to a fair determination of the applicant's rights,

(4) A disclosure of personal information is not an unreasonable invasion of a third party's personal privacy if

(b) there are compelling circumstances affecting anyone's health or safety and notice of disclosure is mailed to the last known address of the third party,

Section 25 Information must be disclosed if in the public interest

(1) Whether or not a request for access is made, the head of a public body must, without delay, disclose to the public, to an affected group of people or to an applicant, information

(a) about a risk of significant harm to the environment or to the health or safety of the public or a group of people, or

(b) the disclosure of which is, for any other reason, clearly in the public interest.

(2) Subsection (1) applies despite any other provision of this Act.

(3) Before disclosing information under subsection (1), the head of a public body must, if practicable, notify

(a) any third party to whom the information relates, and

(b) the commissioner.

(4) If it is not practicable to comply with subsection (3), the head of the public body must mail a notice of disclosure in the prescribed form

(a) to the last known address of the third party, and

(b) to the commissioner.

Section 26 Purpose for which personal information may be collected

No personal information may be collected by or for a public body unless

(a) the collection of that information is expressly authorized by or under an Act,

(b) that information is collected for the purposes of law enforcement, or

(c) that information relates directly to and is necessary for an operating program or activity of the public body.

Section 27 How personal information is to be collected

(1) A public body must collect personal information directly from the individual the information is about unless

(a) another method of collection is authorized by

(i) that individual,

(ii) the commissioner under section 42(1)(i), or

(iii) another enactment,

Section 29 Right to request correction of personal information

(1) An applicant who believes there is an error or omission in his or her personal information may request the head of the public body that has the information in its custody or under its control to correct the information.

(2) If no correction is made in response to a request under subsection (1), the head of the public body must annotate the information with the correction that was requested but not made.

(3) On correcting or annotating personal information under this section, the head of the public body must notify any other public body or any third party to whom that information has been disclosed during the one year period before the correction was requested.

Section 31 Retention of personal information

If a public body uses an individual's personal information to make a decision that directly affects the individual, the public body must retain that information for at least one year after using it so that the individual has a reasonable opportunity to obtain access to it.

Section 33 Disclosure of personal information

A public body may disclose personal information only

(a) in accordance with Part 2,

(b) if the individual the information is about has identified the information and consented, in the prescribed manner, to its disclosure,

(c) for the purpose for which it was obtained or compiled or for a use consistent with that purpose (see section 34),

(d) in accordance with an enactment of British Columbia or Canada that authorizes or requires its disclosure,

(d.1) in accordance with a provision of a treaty, arrangement or agreement that

(i) authorizes or requires its disclosure, and

(ii) is made under an enactment of British Columbia or Canada,

(e) for the purpose of complying with a subpoena, warrant or order issued or made by a court, person or body with jurisdiction to compel the production of information,

(f) to an officer or employee of the public body or to a minister, if the information is necessary for the performance of the duties of, or for the protection of the health or safety of, the officer, employee or minister,

(i) for the purpose of

(i) collecting a debt or fine owing by an individual to the government of British Columbia or to a public body, or

(ii) making a payment owing by the government of British Columbia or by a public body to an individual,

(k) to a member of the Legislative Assembly who has been requested by the individual the information is about to assist in resolving a problem,

(l) to a representative of the bargaining agent who has been authorized in writing by the employee, whom the information is about, to make an enquiry,

(n) to a public body or a law enforcement agency in Canada to assist in an investigation

(i) undertaken with a view to a law enforcement proceeding, or

(ii) from which a law enforcement proceeding is likely to result,

(p) if the head of the public body determines that compelling circumstances exist that affect anyone's health or safety and if notice of disclosure is mailed to the last known address of the individual the information is about,

(q) so that the next of kin or a friend of an injured, ill or deceased individual may be contacted, or

Section 34 Definition of consistent purposes

(1) A use of personal information is consistent under section 32 or 33 with the purposes for which the information was obtained or compiled if the use

(a) has a reasonable and direct connection to that purpose, and

(b) is necessary for performing the statutory duties of, or for operating a legally authorized program of, the public body that uses or discloses the information.

Section 35 Disclosure for research or statistical purposes

A public body may disclose personal information for a research purpose, including statistical research, only if

(a) the research purpose cannot reasonably be accomplished unless that information is provided in individually identifiable form, or the research purpose has been approved by the commissioner,

(b) any record linkage is not harmful to the individuals that information is about and the benefits to be derived from the record linkage are clearly in the public interest,

(c) the head of the public body concerned has approved conditions relating to the following:

(i) security and confidentiality;

(ii) the removal or destruction of individual identifiers at the earliest reasonable time;

(iii) the prohibition of any subsequent use or disclosure of that information in individually identifiable form without the express authorization of that public body, and

(d) the person to whom that information is disclosed has signed an agreement to comply with the approved conditions, this Act and any of the public body's policies and procedures relating to the confidentiality of personal information.

EFFECTIVE DATE: March 3, 2003 (as to the provision of copies of records related to a matter under review or appeal)

APPLICATION: Not applicable.

Relevance of F.I.P.P. to Policy Items

Various items in the Manual deal with policies affecting disclosure or privacy. These are listed below with the appropriate sections of F.I.P.P. relevant to these policies.

Policy Item	Description	F.I.P.P. Reference	Other Reference
45.43	Starting a Business	33(b)	
45.50	Decision-Making Procedures	33(d)	W.C. Act, Sec. 35, 86 and 96
48.20	Money Owing in Respect of Benefits Paid by Other Agencies	33(b)	
48.22	Welfare Payments	33(l)	
48.30	Worker Not Supporting Dependants	3(2) and 22(2)(c), 33(a), (c), (d), (e) and 34	W.C. Act, Sec. 98
49.00	Incapacity Of A Claimant	33(d)	W.C. Act, Sec. 12 and 35(1)
49.13	Application of Section 35(5) in Cases of Temporary Disability	33(d)	W.C. Act, Sec. 35(5)
49.14	Application of Section 35(5) in Cases of Permanent Disability	33(d)	W.C. Act, Sec. 35(5)
49.15	Application of Section 35(5) on a Change of Circumstances	33(d)	W.C. Act, Sec. 35(5)
49.20	Imprisonment of Worker	33(d)	W.C. Act, Sec. 35 and 98(3)
53.10	Person to Whom Expenses are Paid	21, 22, 33(a), (d) and 33(i)(ii) and 34	W.C. Act, Sec. 17
58.00	Foster-Parents	33(d)	W.C. Act, Sec. 17(3)
74.23	Examination by the Board	33(d)	W.C. Act, Sec. 21
74.50	Selection of Physician or Qualified Practitioner	33(d)	W.C. Act, Sec. 21
78.21	Examination at the Board	33(c), 33(d) and 33(i)(ii)	W.C. Act, Sec. 21
78.22	Consultation with Specialists	33(d)	W.C. Act, Sec. 21
78.31	Adjudication of Health Care Benefits Accounts	33(c), (d) and 33(i)(ii)	W.C. Act, Sec. 21
78.32	Reversal of Decision on Appeal	33(c), (d) and 33(i)(ii)	W.C. Act, Sec. 21
87.10	Consultative Process	33(c) and (d)	W.C. Act, Sec. 16
94.12	What Injuries Must Be Reported	26 and 27	
96.22	Suspension of Claim	3(2), 33(c), (d) and (i)(ii)	W.C. Act, Sec. 16, 21 and Div. 4
98.13	Medical Examinations and Opinions	33(d)	W.C. Act, Sec. 21
98.23	Representation	33(d)	W.C. Act, Sec. 88 and 96
98.24	Presence of Employer	3(2) and 33(d)	W.C. Act, Sec. 88 and 96

98.26	Witnesses and Other Evidence	27	
98.27	Cross-examination	27	
99.10	Disclosure of Issues Prior to Adjudication	3(2), 33(b), (c), (d), (l) and 34	W.C. Act, Div. 4, Sec. 90, 91 and 95
99.20	Notification of Decisions	3(2), 22, 33(b), (c), (d), (i) and 34	W.C. Act, Div. 4, Sec. 95
99.21	Notification of Right of Appeal	3(2)	
99.22	Procedure for Handling Complaints or Inquiries About a Decision	33(b), (d) and (i)	W.C. Act, Div. 4, Sec. 95
99.23A	Unsolicited Information — Anonymous	15, 19(1)(a), (b)	
99.23B	Unsolicited Information — Identified	19(2), 31 and 33	
99.24	Notification of Pension Awards	3(2), 33(c) and (d)	W.C. Act, Div. 4, Sec. 90 and 91
99.31	Eligibility for Disclosure	Part 2, 3(2), 22(2)(c), 33(b), (c), (d) and (l)	W.C. Act, Div. 4, Sec. 95
99.32	Provisions of Copies of File Documents	33(b), (d) and 75	W.C. Act, Div. 4, Sec. 95
99.33	Personal Inspection of Files	9	
99.35	Complaints Regarding File Contents	29(3)	
99.40	Tape Recordings of Interviews	4(1) and 33(d)	W.C. Act, Div. 4, Sec. 95
99.41	Transcripts of Workers' Compensation Review Board Hearings	3(2), 4(1) and 33(d)	W.C. Act, Div. 4, Sec. 95
99.50	Disclosure to Public or Private Agencies	33(b), (d), (e), (k), and (p)	W.C. Act, Sec. 95
99.51	Legal Matters	3(2), 33(d) and (e)	
99.52	Other Workers' Compensation Boards	33(d)	W.C. Act, Sec. 8(2)
99.53	The Canada Employment and Immigration Commission	33(b) and 33(d)	U.I. Act, Sec. 94(11)
99.55	Ministry of Social Services	33(i)(ii)	
99.56	Police	33(b), (n) and (q)	
99.60	Information to Other Board Departments	25 and 33(f)	
99.80	Insurance Companies	33(b)	
99.90	Disclosure for Research or Statistical Purposes	34	
102.32	Initiation of Appeal	3(2)	
102.41	Board Files	3(1)(b)	
102.42	Oral Hearings	4(1)	
102.50	Referral of Review Board Findings	3(2)	
103.92	Disclosure and the Freedom of Information and Protection of Privacy Act	33(a) and 19(2)	W.C. Act ss. 58 to 65
105.10	Appeals to the Workers' Compensation Review Board — New Claims	3(2)	
107.10	Distinction Between Reopening and New Claim	3(2)	
108.30	Readjudication Within the Compensation Services Division	3(2), 22(2)(c) and 33(d)	W.C. Act, Div. 4, Sec. 21, 90 and 91
109.10	Workers' Advisers	33(d)	W.C. Act, Sec. 95
109.20	Employers' Advisers	33(d)	W.C. Act, Sec. 95

109.30	Ombudsman	33(d)	Ombudsman Act, Sec. 15
111.25	Pursuing of Subrogated Actions by the Board	3(2) and 33(f)	
111.40	Certification to Court	33(d)	W.C. Act, Sec. 11
113.00	Introduction	33(d)	W.C. Act, Div. 4, Sec. 42 and 47
113.20	Occupational Diseases	3(2)	
114.43	Procedure Governing Applications under Section 39(1)(e)	3(2)	
115.11	Procedure for Applying Section 47(2)	33(d) and 33(i)	W.C. Act, Sec. 47(2)
115.31	Injuries or Aggravations Occurring in the Course of Treatment or Rehabilitation	3(2)	

Section 95(1) of the Act provides that "Officers of the board and persons authorized to make examinations or inquiries under this Part must not divulge or allow to be divulged, except in the performance of their duties or under the authority of the board, information obtained by them or which has come to their knowledge in making or in connection with an examination or inquiry . . ."

It further provides:

(1.1) If information in a claim file, or in any other material pertaining to the claim of an injured or disabled worker, is disclosed for the purpose of this Act by an officer or employee of the board to a person other than the worker, that person shall not disclose the information except

(a) if anyone whom the information is about has identified the information and consented, in the manner required by the board, to its disclosure,

(b) in compliance with an enactment of British Columbia or Canada,

(c) in compliance with a subpoena, warrant or order issued or made by a court, person or body with jurisdiction to compel the production of information, or

(d) for the purpose of preparing a submission or argument for a proceeding under this Part.

(1.2) No court, tribunal or other body may admit into evidence any information that is disclosed in violation of subsection (1.1).

Every person who violates Subsection (1) of (1.1) commits an offence. (38) The maximum fine for this offence is set out in Part 1 of Appendix 6.

#99.10 Disclosure of Issues Prior to Adjudication

Where a claim is protested by an employer, the Adjudicator is required to investigate the matter. In most cases this investigation involves contact with the worker. Normally, most workers at that time become aware of the protest. In some situations a protested claim may be quickly resolved and the claim accepted. In such cases workers may not be aware of the protest.

As part of the investigation which precedes a decision to disallow a claim, the Adjudicator in virtually every case will have communicated with the claimant. These communications may be by telephone, in person or in writing. Through the medium of these communications the claimant is made aware of the nature of the problem and has an opportunity for input and comment. If, however, for some reason an Adjudicator concludes that a claim may not be acceptable, the claimant is contacted before a decision is reached. The contact provides the claimant with an opportunity for input and comment. In situations involving serious cases or complex issues where no prior contact has been made with the claimant, the details should be communicated in writing. Where this is done, the possibility of obtaining assistance from a union official or other adviser may be brought to the claimant's attention.

The Board will cooperate with and notify claimants' or employers' advocates or representatives of any decisions which have been made and communicated to the claimant or employer. Unions or other similar associations may appoint specific officers as designated advocates and list their names with the Board. Information may be disclosed to such advocates when acting on behalf of claimants. Written authorization is required in order to release information to any other advocate, representative or other person designated by the claimant.

Where an employer has protested a claim which, upon investigation, appears to be valid, the Adjudicator should, before making the decision, phone the employer to ensure that the employer is aware of the issues relevant to the protest and has an opportunity to comment.

#99.20 Notification of Decisions

Where a claim is allowed and there has been no protest from the employer, no reasons are given. The Board simply sends the cheque. Notification of the allowance is sent to any advocate designated by the claimant's designated union or association who is acting on behalf of the worker. Information may also be disclosed to any other advocate, representative or other person where authorized in writing by the worker.

When a decision is made to allow a claim that has been protested by an employer, the employer will be notified of the decision and reasons, where possible by telephone. Only personal information which is relevant to the claim and the issues involved will be provided to the employer. A letter explaining the decision and reasons will be sent in any case where the employer cannot be contacted by telephone, or where in the course of the telephone conversation the employer indicates that in spite of the explanation there is a dissatisfaction with the decision. The letter is sent to the employer, with a copy to the worker. The guidelines outlined in the following paragraph, with regard to letters sent to workers, should be followed to the extent that they apply. Employer advocates are notified in the same manner as workers' representatives.

Where a decision is made adverse to a worker, the reasons are stated in a letter to the worker. The guidelines set out below apply in writing these letters. The Board officer will, where appropriate:

1. Specify clearly the matter being adjudicated.

2. Describe investigations carried out, including interviews conducted.

3. Outline the evidence considered.

4. Explain how the evidence was evaluated (specify its reliability; analyze conflicting evidence; give reasons for the weight apportioned to the evidence).

5. Review contact with the worker where the relevant issues were discussed and detail the worker's response.

6. List the various conclusions possible from the evidence.

7. In support of the conclusion reached, explain:

    a) what evidence was considered favourable, with reasons, and
    b) what evidence was considered unfavourable, or discounted, with reasons.

8. Point out statutory, policy or discretionary factors involved.

9. Discuss the question of evenly weighted evidence.

10. Summarize the formal decision.

11. Explain what the decision entails regarding non-payment of wage loss compensation, medical accounts, other benefits, etc.

12. Include an explanation of the relevant rights of review and/or appeal.

A copy of the decision letter will be sent to the employer, and to any advocate designated by the worker's union or association who is acting on behalf of the worker. Information may also be disclosed to any other advocate, representative or other person where authorized in writing by the worker. A copy may also be sent to the physician where the decision involves medical factors. In all other cases, such as, a notification to a pharmacy, a simple letter or notification will be sent.

The term "reject" in decision letters is different than a "disallow" and refers to a claim where:

1. a self-employed worker has no personal optional protection;

2. the claimant was employed by an employer not covered under the *Act*;

3. a report was submitted in error. Normally, this occurs when a physician, on the basis of a misunderstanding, submits a report in error.

Where a claim has been reopened, the employer is notified of the decision either directly or by receiving a copy of the notification sent to the worker.

EFFECTIVE DATE: March 3, 2003 (as to references to evenly weighted evidence and the rights of review and/or appeal)

APPLICATION: To all adjudicative decisions on or after the effective date.

#99.21 Notification of Rights of Review and Appeal

In any case where an adverse decision that is reviewable and/or appealable is made with regard to a worker, the worker will be informed of rights of review and/or appeal. The employer will be informed of rights of review and/or appeal where a claim that he or she protested is accepted, where a request for relief of costs is denied or where a request to limit compensation entitlement is denied. In all other cases where an employer makes it known that he or she disagrees with a decision, information about the review and appeal process will be made available to the employer. If a claim is rejected on the basis that it did not involve an employer covered under the *Act* or there was no personal optional protection in force, notification of the review and/or appeal procedures is not automatically conveyed to the injured person.

In occupational disease claims, where there are a number of different employers identified, but none of the employers are responsible for 20% of the exposure, or more, decision letters and review and/or appeal information are sent to the employers' association that best represents the appropriate sector and rate group of industry.

EFFECTIVE DATE: March 3, 2003 (as to references to review and appeal)

APPLICATION: To all adjudicative decisions on or after the effective date.

#99.22 Procedure for Handling Complaints or Inquiries About a Decision

Board officers frequently receive letters, telephone calls and visits from workers, employers and their representatives concerning the decisions they make on claims. Generally, the party in question will be either asking for further explanation of the decision or expressing dissatisfaction with the substance of the decision.

Where the worker, employer or representative is requesting further explanation, this should be given. In the case of representatives, it will require an authorization except where an advocate designated by the claimant's union or association is acting on behalf of the claimant. Where, however, dissatisfaction is expressed with the substance of the decision, the procedure outlined in C14-103.01 is followed. This procedure is intended only to cover situations where the worker, employer or representative is dissatisfied with the substance of a decision on a claim. It is not intended to cover complaints concerning the general administration of the claim, for example, delays in processing, which should simply be addressed to the Board officer handling the claim or to her or his manager in the Compensation Services Division.

At no time is a letter expressing dissatisfaction with the substance of a decision to be simply committed to the claim with no further action taken.

EFFECTIVE DATE: March 3, 2003 (as to reference to C14-103.01 and deletion of references to Review Board)

APPLICATION: To all adjudicative decisions on or after the effective date.

#99.23 Unsolicited Information

Unsolicited information will not be placed on the worker's claim until it has been assessed for relevancy and accuracy.

Where the Board receives unsolicited information about a worker, the following principles apply:

1. Unsolicited information that is clearly irrelevant to the administration of the worker's claim will be destroyed.

2. Unsolicited information that appears to be relevant or potentially relevant to the administration of the worker's claim will be investigated for accuracy.

3. Where, after investigation, the information is determined to be inaccurate or its accuracy is unknown, the information will be destroyed, including any record that initiated the investigation, the investigation report and any documentation obtained in connection with the investigation.

4. Where, after investigation, the information is determined to be accurate, a final assessment as to relevancy will be made.

5. Where accurate information is considered to be irrelevant to the administration of the worker's claim, the information will be destroyed, including any record that initiated the investigation, the investigation report and any documentation obtained in connection with the investigation.

6. Where accurate information is considered to be relevant or potentially relevant to the administration of the worker's claim, the information is placed on the worker's claim as follows:

   (a) anonymous information — The investigation report and any documentation obtained in connection with the investigation will be placed on the claim. The record that initiated the investigation will be destroyed and the claim will state that the investigation was initiated on the basis of information received.

   (b) information from identified source — The record that initiated the investigation, the investigation report and any documentation obtained in connection with the investigation will be placed on the claim.

   An identified source will be advised that the information may be disclosed to the worker. If the identified source wishes to become anonymous at any time, the information will be treated as anonymous information under (a) above. If the identified source wishes to remain identified, this will be recorded on the worker's claim.

7. If only some of the information is accurate and only some of the accurate information is relevant or potentially relevant to the administration of the worker's claim, the record that initiated the investigation will be destroyed and reference will only be made on the worker's claim to information that is both accurate and relevant or potentially relevant.

8. If, during the investigation, accurate information is discovered that is unrelated to the subject matter of the unsolicited information, but is relevant to the administration of the worker's claim, that information will be recorded separately on the worker's claim.

9. Where unsolicited information is found to be accurate and relevant or potentially relevant to the administration of the worker's claim, the worker will be advised of the information and given an opportunity to comment. Complaints about the accuracy and relevancy of unsolicited information will be dealt with according to #99.35 - Complaints Regarding File Contents.

#*99.24 Notification of Pension Awards*

When a permanent disability award is granted, the letter advising of the award will include the permanent functional impairment evaluation report on which the award has been based. It will also contain the percentage rate of disability assessed. Where the case is one of Proportionate Entitlement, the letter will state the nature and extent of the pre-existing disability and the nature and extent of the further disability. A copy of the letter is sent to the employer. This letter will include information regarding the relevant rights of review and/or appeal.

Other than to the employer or the worker, the amount being paid per month for a pension will only be disclosed to public or private agencies in accordance with the criteria for disclosure as set out in policy item #99.50.

The amount of the capital reserve is disclosed to the employer when notified of the award. The reserve amounts will be given to the worker on request.

EFFECTIVE DATE: March 3, 2003 (as to references to review and appeal)
APPLICATION: Not applicable.

#99.30 Disclosure of Claim Files

The claim file is the master file for recording information used in the adjudication and administration of a claim. Information may exist outside of the claim file. However, all evidence used in the adjudication of the claim is contained in the claim file. When obtained by the Adjudicator or other Board officer, the opinions of both outside physicians and Board Medical Advisers, as well as any further comments on the part of the Adjudicator or other Board officer, are all recorded on, and become part of, the claim file.

Sensitive personal information that is received, which has not been specifically requested and which is not relevant to the adjudication or administration of the claim will not become part of the claim file. It will normally be destroyed. However, where the original document is still in the Board's possession, it will be returned to the sender when requested by the worker or sender. When the Adjudicator or other Board officer has questions about the relevancy of information received, the information shall be brought to the attention of a Manager. The Manager shall make the decision as to whether information received is sensitive or irrelevant and whether the information should be placed on the claim file.

Discretion is necessary in documenting the file to ensure that rumour or innuendo is not mistakenly reported as fact where it is unsupported or cannot be verified. Board staff members should confine their file comments regarding claimants, employers and other persons involved in the claim to relevant matters which they have observed personally or for which there is other supporting evidence. They should confine their observations to the particular circumstances of the claim or other matter and should not make general comments about an individual's personality. They should word their comments in the least offensive way possible and avoid derogatory terms.

In recognition of the sensitive nature of sexual assault claims where the employer is alleged to be the perpetrator of the assault, all such cases, regardless of the residence of the worker, are assigned to the Sensitive Claims Area. Disclosure of these claim files for review or appeal and other legal purposes is administered by the Sensitive Claims Area.

EFFECTIVE DATE: March 3, 2003 (as to reference to review)
APPLICATION: Not applicable.

#99.31 Eligibility for Disclosure

Disclosure of their claim files is provided to a worker or dependant on request. Only one copy is provided and no fee is charged for this disclosure.

After a review or appeal has been initiated, an employer may obtain disclosure. An employer may obtain disclosure even though the worker has not requested disclosure.

Disclosure will be provided to the representative of the employer or worker if authorized in writing.

Where there is a valid review or appeal in process regarding a matter arising under a claim to which another claim is also relevant, disclosure to the employer will also be allowed of the other claim. However, there must be a request for disclosure of that particular claim. The Board will not accept requests of a

general nature for any files which may be relevant to the reviewable or appealable decision or the issue under review or appeal.

A worker may submit a request for update disclosure where information has been added to the file since the previous disclosure. Where disclosure has been granted to a worker, dependant or employer in situations involving a review or appeal, file updates are automatically provided up to the time the review or appeal is heard. The file may be inspected if it is so desired.

EFFECTIVE DATE: March 3, 2003 (as to reference to review)
APPLICATION: Not applicable.

#99.32 *Provision of Copies of File Documents*

A copy of all the documents on the claim file will be sent out automatically on receipt of a request for disclosure from a claimant or an authorized representative.

Where an employer has a right to receive disclosure of a claim file, that disclosure will consist of the same disclosure which would be granted to the claimant.

Only one copy of each claim file is provided. The person entitled to disclosure must decide whether the copy is to go to them or to an authorized or a designated advocate or representative or, if there is more than one, which of them should receive the copy.

File copies may be mailed out or picked up at a Board office.

Effective May 1, 1993, no fees are charged workers for the copy of their claim files. Fees are also not charged employers for a copy of claim files where they are entitled to disclosure.

#99.33 *Personal Inspection of Files*

If the recipient of the copies wishes, an appointment may be made to inspect the file in person.

Personal inspection of the file may take place at the Board's Richmond office or at any other Board office outside the Richmond area by prior appointment only. The office used in each case will be the one closest to the requestor's residence, unless another office is specifically named.

Any person attending at a Board office to view a file in person or to pick up copies will normally be required to provide personal identification containing the person's photograph (e.g. driver's licence) and a social insurance card.

Personal inspection of the file will take place in the presence of a Board officer. This officer will explain the general layout of the claim, but will be instructed not to answer enquiries about the contents of file documents. Explanations about what is in the file must be sought from the person or body dealing with the matter, a Workers' Adviser, an Employers' Adviser, or the person's own representative.

#99.34 Disclosure

As soon as practicable, after a request for a review has been filed, the Board must provide the parties to the review with a copy of its records respecting the matter under review.

As soon as practicable after the Board has been notified by the Workers' Compensation Appeal Tribunal that an appeal has been filed, the Board must provide the parties to the appeal with a copy of its records respecting the matter under appeal.

If it is not a review or appeal situation, a worker may obtain disclosure through the Client Service Manager of the appropriate Service Delivery Location. Where disclosure is available pursuant to the disclosure policies if it is desired simply to inspect the original file in person at an office of the Board outside of the Richmond area, without receiving a copy of the file or after the receipt of a copy, the request may be made directly to the Board office concerned.

Requests for disclosure involving information relating to sexual assault claims where the employer is alleged to be the perpetrator of the assault will be referred to the Sensitive Claims Area (see policy item #99.30).

EFFECTIVE DATE: March 3, 2003
APPLICATION: To disclosures on or after the effective date.

#99.35 Complaints Regarding File Contents

Only where it is personal information which is irrelevant to the claim, does the Board permit the deletion or removal from claim files of statements or documents to which a claimant, employer or other person referred to on the file objects. A person making an objection as to the accuracy of file information will be allowed to place on the file statements or material to rebut the statements to which there is an objection. However, the Board will not make a ruling on a dispute over the accuracy of file information save when it is necessary in the normal course of

events for the purpose of reaching a decision on the merits of the claim or other matter. Where the person making the objection is the claimant, anyone who had access to the file in the one-year period prior to the annotation to the record will be informed.

A complaint that a comment on a Board file is pejorative may be forwarded to the President. If it is concluded that the comment is pejorative, the comment will be stamped, or annotated electronically where appropriate, to identify the comment as pejorative and to refer the reader to the correcting documentation.

#99.40 Tape Recordings of Interviews

Where an enquiry interview has been conducted by a Board officer, a copy of the tape recording of the interview will be supplied upon request to the claimant or their authorized or designated representative. If a review has been requested or an appeal has been filed, a copy may also be provided to the employer or their authorized representative.

A person being interviewed, or any other person entitled to be present at an enquiry, may, if desired, record the proceedings.

EFFECTIVE DATE: March 3, 2003 (as to reference to review)
APPLICATION: Not applicable.

#99.50 Disclosure to Public or Private Agencies

Where a public or private agency requests disclosure of all or part of a claim file, the Board will only comply with the request in keeping with the provisions of the *Freedom of Information and Protection of Privacy Act* (F.I.P.P.). The following are the more common examples where disclosure will be provided in response to such a request:

(a) Where an appropriate signed consent has been received from the worker.

(b) To any agency having statutory authority allowing access to personal information.

(c) To comply with a subpoena, warrant or order issued or made by a court, person or body with jurisdiction to compel the production of the information.

(d) To a member of the Legislative Assembly who has been requested by the worker to assist in resolving a problem.

(e) If the Board determines that compelling circumstances exist which affect the health or safety of an individual.

#99.51 Legal Matters

If a staff member is directly served with a subpoena, the Board's General Counsel or delegate must be advised immediately. If a request is received from a lawyer for information from a claim file, the request is forwarded to the Legal Disclosure Clerk.

At the request of the Board's General Counsel, a Director in the Compensation Services Division may appoint an Adjudicator or other Board officer to be responsible for responding to a subpoena or other request for information from a lawyer.

#99.52 Other Workers Compensation Boards

The Board has authorized the exchange of copy documents with other Boards. The Board will also inform other Boards of the amount of any pension being paid to a claimant by this Board.

#99.53 The Canada Employment and Immigration Commission

In referring workers to Canada Employment Centres for assistance in job placement, a Rehabilitation Consultant may, with the worker's signed consent, furnish the agency with a brief description of their physical limitations.

The *Unemployment Insurance Act* contains a provision in Section 94(11) which gives the Commission the statutory authority to require the disclosure of information necessary for the administration of the Act. Information will, therefore, be provided where a formal demand in accordance with Section 94(11) is received from the Commission in connection with a claim for Employment Insurance.

#99.54 Canada Pension Plan

The Board will take all reasonable steps to assist a disabled worker in obtaining benefits to which she or he may be entitled. The Medical Services Department will provide the Canada Pension Plan, on request and with the worker's release, a report setting out the facts pertaining to the claim, a report to include the date

and nature of the accident, the nature of the injury, a very brief resume of the medical findings and the medical assessment of the remaining permanent disability. The Plan is provided with the names of practicing doctors who had been involved in the case. There is no charge for this information.

Effective September 3, 1996, the F.I.P.P. Department of the Board will handle requests from the Canada Pension Plan for information. Where the Board receives a request authorized by the worker or by statute, the F.I.P.P. Department will provide Canada Pension Plan with copies of documents specified in the request. Any charge for this service is paid by CPP.

#*99.55 Ministry of Social Services*

If the Ministry of Social Services has a debt owing to them, the Board will disclose to the Ministry the amount of any compensation being paid by the Board.

#99.56 Police

Information may be disclosed to police departments for the purpose of contacting a next of kin or for the purposes of a law enforcement proceeding.

#*99.57 Government Employees Compensation Act*

Where an election form signed by the worker is on file, information contained in third party claims for employees covered under the *Government Employees Compensation Act* may be released to the Government of Canada in order to properly pursue the right of action to which it is subrogated.

#99.60 Information to Other Board Departments

Claims Adjudicators and Claims Officers are instructed by the Board to refer to the Prevention Division, for inspection and prevention purposes, the details of any claims received where there is a potential to prevent further recurrences of the situation reported. Examples of this would be scaffolding collapses, explosions, excavation cave-ins, dangerous work practices, etc. Referral is also made in every case where a worker complains about work safety conditions. Where an Adjudicator or Claims Officer is aware of an excessive number of injuries of the same type or even of a different type with one employer, a notification of this observation is also sent to the Prevention Division.

#99.70 Media Enquiries or Contacts

Unless designated as a media spokesperson, staff at the head office of the Board must refer all media enquiries or contacts to the Community Relations Department. Enquiries received in area offices should be referred to the Area Office Manager.

#99.80 Insurance Companies

On receipt of a signed consent from the worker or dependant, information from a claim file to which the worker or dependant would have access may be disclosed to an insurance company. The signed consent must be directed specifically to the Board and clearly state the information which may be released. It should also refer to a specific claim or specific claims, and must have been signed within 24 months of its date of receipt. See also #48.20.

#99.90 Disclosure for Research or Statistical Purposes

The Board may disclose personal information for a research purpose, including statistical research, only if:

(a) the research purpose cannot reasonably be accomplished unless that information is provided in individually identifiable form or the research purpose has been approved by the Information and Privacy Commissioner.

(b) any record linkage is not harmful to the individuals that information is about and the benefits to be derived from the record linkage are clearly in the public interest.

(c) the Board has approved conditions relating to the following:

  (i) security and confidentiality;

  (ii) the removal or destruction of individual identifiers at the earliest reasonable times;

  (iii) the prohibition of any subsequent use or disclosure of that information in individually identifiable form without the express authorization of the Board, and

(d) the person to whom that information is disclosed has signed an agreement to comply with the approved conditions, the provisions of the *Freedom of Information and Protection of Privacy Act* and any of the Board's policies and procedures relating to the confidentiality of personal information.

#100.00 REIMBURSEMENT OF EXPENSES

Set out below are the rules relating to the reimbursement of expenses for people attending at the Board or elsewhere in connection with claims or Review Division inquiries.

The principles relating to expenses incurred in connection with medical examinations and treatment and vocational rehabilitation programs are dealt with in policy item #82.00 and policy item #83.00.

The Board may be ordered by the Workers' Compensation Appeal Tribunal to pay certain expenses. Section 7 of the *Workers Compensation Act Appeal Regulation* (B.C. Reg. 321/2002) provides that the Board may be ordered by the Workers' Compensation Appeal Tribunal to reimburse a party to an appeal under Part 4 of the *Act* for the following kinds of expenses:

- expenses associated with attending an oral hearing or otherwise participating in a proceeding, if the party is required by the Workers' Compensation Appeal Tribunal to travel to the hearing or other proceeding;

- expenses associated with obtaining or producing evidence submitted to the Workers' Compensation Appeal Tribunal; and

- expenses associated with attending an examination required under section 249(8) of the *Act*.

However, the Workers' Compensation Appeal Tribunal may not order the Board to reimburse a party's expenses where those expenses arise from a person representing the party or the attendance of a representative of the party at a hearing or other proceeding related to the appeal.

EFFECTIVE DATE: March 3, 2003 (as to references to the Review Division, the Workers' Compensation Appeal Tribunal and section 7 of the *Workers Compensation Act Appeal Regulation*)

APPLICATION: To adjudicative decisions on or after the effective date.

#100.10 Claimants

In addition to the specific requirements set out below, the worker must satisfy the general requirements in #82.10 and #83.10 for the payment of transportation and subsistence.

#100.12 Claims or Review Inquiries

Where a worker is attending on a claims or review inquiry, the payment of expenses is discretionary. There will be no undertaking to pay expenses and no advance.

1. Where the claims inquiry or review results in a decision for the claimant, the discretion will normally be exercised in favour of payment. But payment should be refused if it is concluded that the inquiry or review was brought about unnecessarily by the worker.

   For example, payment might be refused on a review where it is concluded that the denial of the claim in the first instance resulted from misleading information supplied by the worker.

2. Where the claims inquiry or review results in a decision against the worker, payment of expenses will normally be refused. But payment may be allowed if there is special reason. An example might be, where, although the claim was unfounded, the bringing of the review resulted from misleading reasons for the decision being given in the first instance.

These provisions apply only where people are notified to come for a formal claims or review inquiry. Expenses are not reimbursed for people coming to the Board to make enquiries, or for ordinary discussions.

EFFECTIVE DATE: March 3, 2003 (as to references to review)
APPLICATION: Not applicable.

#100.13 Medical Review Panels

On an appeal to a Medical Review Panel under Section 58(3) or (4) or a referral to a Medical Review Panel by the Board under Section 58(5), expenses will be paid regardless of the result, unless it is concluded that the worker was misleading the Board or the doctor who completed the certificate initiating the appeal. Travel warrants may be issued, and accommodation in the Rehabilitation Residence (40) may be offered if required. #100.15 applies where the worker resides outside the province.

#100.14 Amount of Expenses

The amount of expenses paid is calculated in accordance with the rules set out in #82.20 (transportation), #83.20 (meals and accommodation) and #83.13 (lost time from work where the worker is not already in receipt of temporary disability or vocational rehabilitation benefits from the Board).

#100.15 Worker Resides Outside the Province

The general principle stated in policy item #82.10 is that, where the Board is paying travel costs of a worker located outside the province, it will only pay the portion attributable to travel in this province. This also applies to claims and review inquiries but there are some exceptions to this principle which apply here.

Where a worker resides outside the province and is specifically requested by the Board to attend a claims inquiry or a review by the Review Division, the full cost of the trip will be paid by the Board.

Where a worker resides outside the province and appeals to a Medical Review Panel, the worker is advised that, following the receipt of the panel's certificate, the Board may decide to pay expenses for the whole journey. In reaching the decision, the Board considers the contents of the panel certificate.

If the Medical Review Panel appeal is initiated by the employer or the referral to the Medical Review Panel is made by the Board, the full costs of the journey will be paid.

EFFECTIVE DATE: March 3, 2003 (as to references to review)
APPLICATION: Not applicable.

#100.20 Employers

The expenses of an employer's representative may be reimbursed on the same basis as for a claimant, except that compensation benefits for lost time from work are not payable.

Not more than one employer's representative will be eligible for reimbursement for attendance at a claims inquiry or a review by the Review Division unless the second or other representative is needed as an additional witness.

EFFECTIVE DATE: March 3, 2003 (as to reference to the Review Division)
APPLICATION: Not applicable.

#100.30 Witnesses and Interpreters

The expenses of a witness or interpreter will be paid when they have been subpoenaed or have been requested to attend by the Board.

In other cases, the expenses of an independent witness will be paid where, following the claims inquiry or review by the Review Division, it appears that it was reasonable for the claimant or employer as the case may be to have

assumed, prior to the claims inquiry or review by the Review Division, that the attendance of the witness would be necessary. (If a claimant or employer intends to bring more than two witnesses, or intends to bring any witness from a distance of more than twenty-five miles, they should check first by telephone with the Board officer or the review officer, as the case may be.)

Where the expenses of a witness are payable, the amount will be the same as for a claimant. Income-loss benefits under policy item #83.13 will be paid for lost time from work. The applicable maximum and minimum will be those in effect at the time the lost time is incurred. Prior to September 1, 1992, a special witness lost earnings allowance was paid as follows:

Witness Expenses

Date	**Amount Per Half-Day**
January 1, 1983 – December 31, 1983	$36.96
January 1, 1984 – September 30, 1989	40.44
October 1, 1989 – February 28, 1991	47.00
March 1, 1991 – August 31, 1992	49.00

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

EFFECTIVE DATE: March 3, 2003 (as to references to the Review Division)
APPLICATION: Not applicable.

#100.40 Fees and Expenses of Lawyers and Other Advocates

No expenses are payable to or for any advocate. Nor does the Board pay fees for legal advice or advocacy in connection with a claim for compensation. (41) The Board will not pay the legal costs of a claimant or employer in connection with court proceedings to challenge a Board decision beyond what it may become subject to pay following the court's decision under the general law of costs.

#100.50 Expenses Incurred in Producing Evidence

Where a claimant incurs expense in producing evidence of a kind which the Adjudicator would have sought had it not been produced by the claimant, these expenses will be reimbursed by the Board as an item of administrative cost. In this connection, it makes no difference whether the expense was incurred directly or through a lawyer or other representative. However, confusion should not be made between the expenses incurred by the lawyer or other representative on

behalf of the claimant and the fees of the lawyer or representative for work done. Only the former are reimbursable.

The cost of medical reports obtained by a claimant or employer will also be paid by the Board where, following the claims inquiry or review by the Review Division, it appears reasonable for them or their representative to have assumed, prior to the claims inquiry or review by the Review Division, that the provision of the report was necessary. These costs may be paid even if, after the matter is concluded, it is determined that they had not specifically served to assist in the enquiry.

The Board, in a decision on a claim, refused to pay for medical reports obtained by a claimant's lawyer. Although it was a normal and prudent action on the part of a responsible lawyer to seek information in order to acquaint himself properly with his client's problem before pursuing it before the Board, the information contained in the reports could have been obtained from the claimant's attending physician at no cost. A simple request to the attending physician, together with a release from the claimant, would have been sufficient.

It is not the Board's intention that claimants or employers should incur costs in obtaining evidence, for example, accountants' fees for producing earnings information. Rather, the general approach is that the claimant or employer should advise the Board of possible sources of information and the Board should carry out the necessary inquiries.

EFFECTIVE DATE: March 3, 2003 (as to references to the Review Division)
APPLICATION: Not applicable.

#100.60 Decision on Expenses

With regard to claims inquiries, any necessary decisions relating to expenses would be made by the Board officer. With regard to reviews or appeals, decisions relating to expenses are made by the Review Division or the Workers' Compensation Appeal Tribunal, respectively.

EFFECTIVE DATE: March 3, 2003 (as to references to the Review Division and the Workers' Compensation Appeal Tribunal)
APPLICATION: Not applicable.

#100.70 The Awarding of Costs

The provisions in policy item #100.00 to policy item #100.60 relate to the payment of expenses by the Board. An order for the payment of costs by one party to another under section 100 of the *Act* is a separate matter, and is an alternative that may be considered in an appropriate case.

Section 100 provides that "The Board may award a sum it considers reasonable to the successful party to a contested claim for compensation or to any other contested matter to meet the expenses the party has been put to by reason of or incidental to the contest, and an order of the Board for the payment by an employer or by a worker of a sum so awarded, when filed in the manner provided for the filing of certificates by section 45(2), becomes a judgment of the court in which it is filed and may be enforced accordingly."

A "contested claim", for the purposes of section 100, is one in respect of which there has been a review by the Review Division by the worker or the employer. An appeal to a Medical Review Panel might amount to a "contest" of a claim but it is unlikely that a question of costs would arise in such a case.

An award under section 100 might be made on a review but only in unusual cases. The section is limited to cases where the worker or employer abuses their respective rights under the *Act*. For instance, the worker or employer may put the opposite party to the expense of an appeal for no good reason. In other words, it may appear that a review was pursued simply because the right to request a review existed and without any substantial grounds on which the position could be argued.

An award will not likely be made under section 100 in favour of a successful appellant. The section requires that the expenses in respect of which the award is made be ". . . by reason of or incidental to the contest, . . ." Since the appeal will be proceeded with and resolved whether or not it is opposed by the other party, it cannot normally be said that the expenses of the appellant are due to the other party's "contest" of the review. Where the review is not opposed by the other party, the reasons for not making an award become even stronger.

Section 6 of the *Workers Compensation Act Appeal Regulation* (B.C. Reg. 321/2002) provides that the Workers' Compensation Appeal Tribunal may award costs related to an appeal under Part 4 of the *Act* to a party if the Workers' Compensation Appeal Tribunal determines that:

- another party caused costs to be incurred without reasonable cause, or caused costs to be wasted through delay, neglect or some other fault;
- the conduct of another party has been vexatious, frivolous or abusive; or

- there are exceptional circumstances that make it unjust to deprive the successful party of costs.

EFFECTIVE DATE: March 3, 2003 (as to references to review, the Review Board and section 6 of the *Workers Compensation Act Appeal Regulation*)
APPLICATION: Not applicable.

100.71 Application for Costs by Dependant

On an application under former section 11 of the *Act*, the Board certified that the defendant to a third party action was not an employer under the *Act*. The plaintiff then applied for an order for costs of the proceedings before the Board to be paid by the third party defendant. The Board determined that:

> ". . . the authority of the Board to enforce payment of an order for costs is limited to an order for payment by an employer, or by a worker. The Third Party in this case is neither an employer nor a worker under Part I, and the Board has therefore no authority to make an order for costs against the Third Party. It may well be that this limitation under Section 100 has a historical explanation that does not reflect any rational policy currently relevant. But it is a clear limitation in the Act, and it must therefore be followed."

The question arises whether an award under section 100 can be made in favour of the dependants of a deceased worker. Such an award would not contradict the previous determination, as the person against whom it would be made is an employer under the *Act*. However, it was considered unfair to make such an award if the employer could not get a like award against the dependant. Therefore, an award of costs will not be made in favour of a dependant of a deceased worker against an employer.

EFFECTIVE DATE: March 3, 2003 (as to reference to former section 11)
APPLICATION: Not applicable.

#*100.72 What Costs May Be Awarded?*

It would not be reasonable to make an order for costs against a worker or employer in respect of an expense which the Board would not allow under the rules set out in #100.00-50. Therefore, an award of costs will not include the fees of lawyers and other persons paid to them for advice or advocacy in connection with a claim for compensation.

#100.73 *Decisions on Applications for Costs*

Only in rare cases will a review by the Review Division be sufficiently without merit to justify an award under section 100.

EFFECTIVE DATE: March 3, 2003 (as to reference to the Review Division)
APPLICATION: Not applicable.

#100.75 *Implementation of Review or Appeal Division Directing Reassessment or Redetermination*

It may happen that, instead of reaching a specific finding on a matter, the Review Division or the Workers' Compensation Appeal Tribunal will direct that the Compensation Services Division reassess or redetermine something, for example, a permanent partial disability pension. The Review Division or the Workers' Compensation Appeal Tribunal finding is properly implemented if the reassessment or redetermination is carried out even if the conclusion reached is the same as the one that was previously reviewed by the Review Division or appealed to the Workers' Compensation Appeal Tribunal. However, if the Board officer implementing the Review Division or the Workers' Compensation Appeal Tribunal finding is the same one who made the original decision against which the review or appeal was made, and if that person's decision is still negative, the matter is to be referred to a different Board officer for a second look. If a difference of opinion results from the second look, the decision of the second Board officer will prevail.

Where, in addition to directing the reassessment or redetermination, the Review Division or the Workers' Compensation Appeal Tribunal makes some specific findings of fact, for example, that the worker was unable to carry out certain jobs, the Compensation Services Division is bound by those findings.

Where the reassessment or redetermination results in no change in the original Compensation Services Division decision, a review or an appeal lies back to the Review Division or the Workers' Compensation Appeal Tribunal, respectively.

EFFECTIVE DATE: March 3, 2003 (this policy item was moved from Chapter 13 and amended to include references to the Review Division and the Workers' Compensation Appeal Tribunal)
APPLICATION: Not applicable.

#100.80 PAYMENT OF CLAIMS PENDING APPEALS

#100.81 Appeals to the Review Division – New Claims

The general practice is that no payment is made on a new claim until there has been an adjudication that the claim is valid.

When a decision is made to allow a claim that has been protested by an employer, the employer will be advised of the decision and reasons, where possible by telephone, and given an opportunity to provide any additional information. This is similar to the requirement in policy item #99.10 that a worker be advised if the indication on a claim is that it may be disallowed. If the decision remains that the claim should be allowed, payments will be commenced immediately and a letter explaining the decision and reasons will be sent to the employer. The letter will advise the employer of their right to request a review by the Review Division.

An employer can appeal up to 90 days from the decision allowing a claim.

If the Review Division reverses the decision of the Claims Department to allow the claim, payments are immediately terminated but no attempt is made to recover payment incorrectly made to the worker, unless there was evidence of fraud or misrepresentation. The employer's sector or rate group will be relieved of the claim costs pursuant to policy item #113.10.

EFFECTIVE DATE: March 3, 2003 (this policy item was moved from Chapter 13 and amended to include references to the Review Division)
APPLICATION: Not applicable.

#100.82 Appeals to the Workers' Compensation Appeal Tribunal – Reopening of Old Claims

If a decision is made to reopen an old claim, the employer is advised in writing. If the employer objects to this decision, the employer will be advised of the right to appeal to the Workers' Compensation Appeal Tribunal.

If the Workers' Compensation Appeal Tribunal reverses the decision of the Claims Department to reopen the claim, payments are immediately terminated. No attempt is made to recover payments incorrectly made to the worker unless there was evidence of fraud or misrepresentation. The employer's sector or rate group will be relieved of the claim costs pursuant to policy item #113.10.

EFFECTIVE DATE: March 3, 2003 (this policy item was moved from Chapter 13 and amended to include references to the Workers' Compensation Appeal Tribunal)

APPLICATION: Not applicable.

#100.83 Implementation of Review Division Decisions

Section 258 of the *Act* provides as follows:

(1) If, following a review under section 96.2, a review officer's decision requires payments to be made to a worker or a deceased worker's dependants, the Board must

(a) begin any periodic payments, and

(b) pay any lump sum due under section 17(13).

(2) In the absence of fraud or misrepresentation, an amount paid under subsection (1) to a worker or a deceased worker's dependants is not recoverable.

(3) If a review officer has made a decision described under subsection (1), the Board must defer the payment of any compensation applicable to the time period before that decision

(a) for a period of 40 days following the review officer's decision, and

(b) if the review officer's decision is appealed under section 239, for a further period until the appeal tribunal has made a final decision or the appeal has been withdrawn, as the case may be.

(4) Subsection (3) applies despite sections 19.1, 22(1), 23(1) or (3), 29(1) or 30(1).

(5) If the appeal tribunal's decision on an appeal requires the payment of compensation, all or part of which was deferred under subsection (3), interest must be paid on the deferred amount of that compensation as specified in subsection (6).

(6) Interest payable under subsection (5) must be calculated in accordance with the policies of the board of directors and begins

(a) 41 days after the review officer made his or her decision, or

(b) on an earlier day determined in accordance with the policies of the board of directors.

The procedures for implementing all Review Division decisions are as follows:

1. Any benefits payable from the date of the Review Division decision forward will be paid without delay.

2. Any benefits payable for the period of time prior to the date of the Review Division decision (retroactive benefits) will be paid after 40 days have elapsed following the date of Review Division decision unless an appeal has been filed with the Workers' Compensation Appeal Tribunal**.**

3. If there is an appeal of the decision under section 239 retroactive benefits will not be paid until the Workers' Compensation Appeal Tribunal has made a final decision or the appeal has been withdrawn.

4. The decision of the Workers' Compensation Appeal Tribunal will be implemented upon its receipt by the Board officer. The worker's entitlement to retroactive benefits which were deferred according to #3 above will then be determined in accordance with the decision of the Workers' Compensation Appeal Tribunal.

5. Where retroactive benefits are payable, after the decision of the Workers' Compensation Appeal Tribunal, interest is to be paid in accordance with the Board's general policy on the payment of interest on retroactive benefits as set out in policy item #50.00.

   However, where no interest is payable under policy item #50.00 because it is determined that the retroactive benefit was not necessitated by a blatant Board error, interest will be paid beginning 41 days after the date on which the Review Division made its decision. The amount of interest to be paid is to be calculated in accordance with the interest rates set out in policy item #50.00.

EFFECTIVE DATE: March 3, 2003 (this policy was moved from Chapter 13 and amended to include references to section 258 of the *Act*, the Review Division and the Workers' Compensation Appeal Tribunal and delete a reference to former policy item #45.61)

APPLICATION: Not applicable.

NOTES

(1) S.53(2)
(2) S.53(3)
(3) See #94.11
(4) *Workers' Compensation Board of British Columbia, W.C.B. News*, November – December, 1975, 4
(5) S.50, prior to repeal by S.27, *Workmen's Compensation Amendment Act*, 1974 (hereafter referred to as W.C.A., 1974)
(6) See #93.22
(7) S.55(1)
(8) S.55(4)
(9) S.52, prior to repeal by S.29, W.C.A., 1974
(10) S.55(1)
(11) S.12; See #49.00
(12) S.54(2)
(13) S.54(3)
(14) S.54(6)(b)
(15) S.54(9)
(16) See #34.40
(17) See #74.10
(18) S.56(1)(b)
(19) S.56(1)(c)
(20) S.56(5)
(21) S.56(1)(d)
~~(22) S.99~~ Deleted
(23) See Chapter 16
(24) See #112.30; #113.30
(25) See #73.54
(26) See #34.40
(27) *Workers' Compensation Board of British Columbia, W.C.B. News Bulletin*, September – October, 1973
(28) S.5(4); See #14.10
(29) S.6(3); See #26.21
(30) S.6(11); See #29.50
(31) See #95.10
(32) See #97.10
(33) See #74.60
(34) S.88(2)
(35) S.88(4)
(36) S.88(5)
(37) S.21, *Evidence Act*
(38) S.95(2)
~~(39) See #103.00~~ Deleted
(40) See #84.00
(41) See#48.10

RE: Reviews and Appeals – General **ITEM: C13-100.00**

BACKGROUND

1. Explanatory Notes

The *Workers Compensation Amendment Act (No. 2), 2002* ("*Amendment Act (No. 2), 2002*") has made significant changes to the workers' compensation appeal system.

Prior to the *Amendment Act (No. 2), 2002* being brought into force, the following avenues of appeal existed with respect to compensation and rehabilitation matters:

- initial decisions were appealable to the Workers' Compensation Review Board;
- Review Board findings were appealable to the Board's Appeal Division; and
- initial decisions, Review Board findings and Appeal Division decisions were all appealable on medical issues to Medical Review Panels. MRP decisions on medical issues were binding upon all levels of decision-making in the system.

Provisions of the *Amendment Act (No. 2), 2002* closing access to Medical Review Panels were brought into force effective November 30, 2002. The Medical Review Panels will continue to address appeals submitted prior to that time or in accordance with the transitional provisions of the *Amendment Act (No. 2), 2002*. Once those appeals have been dealt with, the Medical Review Panels will cease to exist.

Other provisions of the *Amendment Act (No. 2), 2002* were brought into force effective March 3, 2003. Except for purposes of addressing certain matters covered by the transitional provisions of the *Amendment Act (No. 2), 2002*, the Workers' Compensation Review Board and the Board's Appeal Division ceased to exist as of that date.

Effective March 3, 2003, the following avenues of review and appeal exist with respect to compensation and rehabilitation matters:

- initial decisions (except decisions on whether to reopen a previous matter) are reviewable by a review officer, who is an officer of the Board;
- most, but not all, review officer decisions are appealable to the independent Workers' Compensation Appeal Tribunal ("WCAT"); and
- initial decisions on whether to reopen a previous matter are directly appealable to WCAT.

In addressing appeals, WCAT may seek independent advice or assistance from a health care professional who appears on a list developed by the WCAT Chair in accordance with the statutory requirements. However, the opinions of the health care professional are not binding upon WCAT.

The Board has established the Review Division comprised of review officers to deal with reviews. For the most part, there will be no policies in relation to the operations of the Review Division. Readers should consult the *Act*, the Review Division and the practices and procedures issued by the Review Division to determine their rights and responsibilities in relation to this review function.

WCAT is independent of the Board. Readers should consult the *Act* and contact WCAT to determine their rights and responsibilities in relation to this appeal function.

There is a section in this Chapter on Medical Review Panels. These policies are required to continue to administer the Medical Review Panel process in respect of appeals submitted prior to November 30, 2002 or in accordance with the transitional provisions of the *Amendment Act (No. 2), 2002*.

There is also a section in this Chapter on Transitional Matters Relating to the Review Board and the Appeal Division. These policies are required for the Review Board and Appeal Division to complete decision-making on certain matters after March 3, 2003 in accordance with the transitional provisions of the *Amendment Act (No. 2), 2002*.

2. The Act

The provisions of the *Act* are too extensive to quote in this Chapter. Readers are referred to the following website for the *Amendment Act (No. 2), 2002* -

http://www.legis.gov.bc.ca/37th3rd/3rd_read/gov63-3.htm

POLICY

There is no POLICY for this Item.

PRACTICE

Readers should consult the Review Division or WCAT to determine whether a pre-March 3, 2003 decision by the Board or by a previous appeal body is reviewable by the Review Division or appealable to WCAT.

EFFECTIVE DATE:	March 3, 2003
AUTHORITY:	*Workers Compensation Amendment Act (No. 2), 2002*
CROSS REFERENCES:	Reviews and Appeals - Review Division - Practices and Procedures (C13-101.00), Reviews and Appeals - Workers' Compensation Appeal Tribunal (C13-102.00), Reviews and Appeals - Medical Review Panels (C13-103.00), Reviews and Appeals - Transitional Matters Relating to the Review Board and the Appeal Division (C13-104.00)
HISTORY:	New Item resulting from the *Workers Compensation Amendment Act (No. 2), 2002*
APPLICATION:	

RE: Reviews and Appeals – Review Division – Practices and Procedures

ITEM: C13-101.00

BACKGROUND

1. Explanatory Notes

The Board may establish practices and procedures for the conduct of reviews. Those practices and procedures are established under the direction of the President of the Board or the President's delegate.

2. The Act

Section 96.4(2):

> Subject to any Board practices and procedures for the conduct of a review, a review officer may conduct a review, as the officer considers appropriate to the nature and circumstances of the decision or order being reviewed.

Section 96(8):

> The Board may establish practices and procedures for carrying out its responsibilities under the Act, including specifying time periods within which certain steps must be taken and the consequences for failing to comply with those time periods.

POLICY

As with other practices or procedures established by the Board, the practices and procedures for the conduct of reviews by the Review Division will be established by the President or under the direction of the President or delegate.

PRACTICE

For any relevant PRACTICE information, readers should consult the Review Division's Practices and Procedures available on the WCB website.

EFFECTIVE DATE: March 3, 2003
AUTHORITY: ss. 96(8) and 96.4(2), *Workers Compensation Act*
CROSS REFERENCES: Reviews and Appeals - General (C13-100.00)
HISTORY: New Item resulting from the *Workers Compensation Act (No. 2), 2002*

APPLICATION:

RE: Reviews and Appeals – Workers' Compensation Appeal Tribunal **ITEM: C13-102.00**

BACKGROUND

1. Explanatory Notes

Effective March 3, 2003, the *Workers Compensation Amendment Act (No. 2), 2002*, has established the Workers' Compensation Appeal Tribunal ("WCAT") as the final level of appeal on most matters in the workers' compensation system. WCAT is external to, and independent from, the Workers' Compensation Board. Its chair is appointed by the Lieutenant Governor in Council. Its vice-chairs and members are appointed by the chair, after consultation with the Minister.

With certain exceptions, a final decision made by a review officer in a review under sections 96.2 to 96.5 may be appealed to WCAT.

Those exceptions are:

- a decision respecting matters referred to in section 16 of the *Act*;
- a decision respecting the application under section 23(1) of the *Act* of rating schedules compiled under section 23(2) where the specified percentage of impairment has no range or has a range that does not exceed 5%;
- a decision respecting commutations under section 35;
- a decision respecting an order under Part 3, other than an order
  - relied upon to impose an administrative penalty under section 196(1);
  - imposing an administrative penalty under section 196(1); or
  - made under section 195 to cancel or suspend a certificate; and
- a decision in a class of decisions prescribed by the Lieutenant Governor in Council respecting the conduct of a review.

In the *Workers Compensation Act Appeal Regulation* (B.C. Reg. 320/2002), the Lieutenant Governor in Council prescribed the following decisions respecting the conduct of a review as not being appealable to WCAT:

- decisions applying time periods specified by the Board under section 96(8) of the *Act* (time periods specified in the Board's practices and procedures for taking certain steps);

- decisions made under the following provisions of the *Act*
    - section 96.2(4) (extensions of time to request a review);
    - section 96.2(7) (deeming an employers' adviser or an organized group of employers to be the employer);
    - section 96.4(2) (subject to any Board practices and procedures, conducting a review as the review officer considers appropriate);
    - section 96.4(3) (completing a review or determining a review has been abandoned if a party does not make a submission within the time required by the Board's practices and procedures);
    - section 96.4(4) (requiring the employer to post a notice in the workplace of reviews relating to certain occupational health and safety matters);
    - section 96.4(5) (suspending a review to allow a review officer to deal with related matters at the same time); and
    - section 96.4(7) (extending the time for a review officer to make a decision);
- an order by the chief review officer under section 96.2(5) that the request for review operates as a stay of proceedings or suspends operation of the decision under review;
- decisions about whether or not to refer a decision back to the Board under section 96.4(8)(b) of the *Act*; and
- decisions respecting the conduct of a review if the review is in respect of any matter that is not appealable to WCAT.

A decision to reopen or not to reopen a matter on an application under section 96(2) may be appealed directly to WCAT.

A determination, an order, a refusal to make an order or a cancellation of an order made by the Board under section 153 (in relation to discriminatory action) may also be appealed directly to WCAT.

2. The Act

The provisions of the *Act* are too extensive to quote in this Chapter. Readers are referred to the following website for the *Amendment Act (No. 2), 2002* -

http://www.legis.gov.bc.ca/37th3rd/3rd_read/gov63-3.htm

POLICY

There is no POLICY for this Item.

PRACTICE

For PRACTICE information about the operation of WCAT, readers should contact WCAT.

EFFECTIVE DATE:	March 3, 2003
AUTHORITY:	ss. 231 to 261, *Workers Compensation Act*; s. 4, *Workers Compensation Act Appeal Regulation* (B.C. Reg. 320/2002)
CROSS REFERENCES:	Reviews and Appeals - General (C13-100.00)
HISTORY:	New Item resulting from the *Workers Compensation Amendment Act (No. 2), 2002*
APPLICATION:	

RE: Reviews and Appeals – Medical Review Panels **ITEM: C13-103.00**

BACKGROUND

1. Explanatory Notes

Prior to November 30, 2002, sections 58 - 66 of the *Act* established rights of appeal on medical issues to Medical Review Panels comprised of independent physicians.

Section 58(3) and (4) of the *Act* established the right of appeal for a worker or employer to have the worker examined by a Medical Review Panel. The worker or employer was required to write to the Board expressing that the worker or employer was aggrieved by a finding of the Review Board or decision of the Board and also to send a certificate from a physician certifying that, in the physician's opinion, there was a bona fide medical dispute to be resolved, and stating sufficient particulars to define the question in issue.

Section 63(1) of the *Act* established the right of appeal for a dependant of a deceased worker. A dependant was entitled to have a Medical Review Panel inquire into and determine the cause of death of the worker if the dependant wrote to the Board expressing that the dependant was aggrieved by a finding of the Review Board or a decision of the Board concerning the cause of death.

Matters covered by the remaining provisions included:

- the right of referral of a worker by the Board to a Medical Review Panel (s. 58(5));
- appointing a Medical Review Panel (s. 59);
- the examination of the worker (s. 60);
- the matters with respect to which a Medical Review Panel was required to certify in giving its decision (s. 61);
- payment of the costs of the examination out of the accident fund (s. 62);
- the preparation of a statement of non-medical facts by the Board (s. 64);
- the conclusive nature of the Medical Review Panel certificate (s. 65); and
- the authority of the Lieutenant Governor in Council to make regulations with respect to the Medical Review Panel process (s. 66).

Effective November 30, 2002, the *Workers Compensation Amendment Act (No. 2), 2002,* ("*Amendment Act (No. 2), 2002*") repealed the rights of appeal under section 58(3) and (4) and section 63(1). With one limited exception, there is no right of appeal under those provisions after that date. That exception covers unexercised appeal rights under section 58(3) and (4). The Transitional Provisions to the *Amendment Act (No. 2), 2002*, provide that if, before November 30, 2002:

- a person has not exercised a right under section 58(3) or (4) of the *Act*; and
- the time period within which that right must be exercised would not have expired but for the repeal of that right on the repeal date,

that person may exercise that right under section 58(3) or (4) before the time period has expired.

The Transitional Provisions to the *Amendment Act (No. 2), 2002* also provide that all proceedings pending under sections 58(3) and (4) and 63(1) of the *Act* on November 30, 2002 are to be continued and completed. The remaining provisions of the *Act* will therefore continue to apply to those proceedings, as well as to any proceedings initiated by the exercise of previously unexercised appeal rights as noted above.

Effective November 30, 2002, *Amendment Act (No. 2), 2002* repealed the Board's right to refer a worker to a Medical Review Panel under section 58(5). Other than as necessary to implement the transitional provisions relating to proceedings under sections 58(3) and (4) and 63(1), the Board no longer has this authority.

Policy items #103.10 to #103.93 set out in the Appendix to Item C13-103.00 immediately following are required to enable the Medical Review Panel proceedings to be continued, completed and implemented in accordance with the transitional provisions.

Other than noted above, there is no longer a Medical Review Panel process under the *Workers Compensation Act*. Section 249 of the *Act* provides a mechanism for the Workers' Compensation Appeal Tribunal ("WCAT") to seek assistance or advice from a list of health care professionals compiled by the WCAT Chair. That advice or assistance is not, however, binding on WCAT.

2. The Act

See Policy items #103.10 to #103.93 in the Appendix to Item C13-103.00 immediately following.

POLICY

Policy items #103.10 to #103.93 in the Appendix to Item C13-103.00 immediately following are continued in relation to the Medical Review Panel process on and after March 3, 2003 insofar as they are consistent with the *Workers Compensation Amendment Act (No. 2), 2002*.

PRACTICE

For any relevant PRACTICE in relation to Medical Review Panels, readers should consult the Medical Review Panel Department of the Workers' Compensation Board.

EFFECTIVE DATE: March 3, 2003
AUTHORITY: *Workers Compensation Amendment Act (No. 2), 2002*
CROSS REFERENCES: Reviews and Appeals - General (C13-100.00)
HISTORY: New Item made necessary because of the *Workers Compensation Amendment Act (No. 2), 2002*

APPLICATION:

APPENDIX TO ITEM C13-103.00

MEDICAL REVIEW PANELS

#103.10 Introduction

Section 58 of the *Act* authorizes a Medical Review Panel process which provides for resolution of bona fide medical disputes which arise in the adjudication of workers' claims.

The Panels are independant of the Board and are appointed on terms and conditions established by the *Act*. Each Panel is composed of three community-based physicians who come together for the purpose of resolving a medical dispute on a particular appeal. Having performed this service the particular Panel is then disbanded.

While each panel is independent of the Board, sections 58 to 64 of the *Act* specifically provide authority for the Board to perform certain duties in the Medical Review Panel process. Amongst other things, these sections authorize the Board to:

- Receive requests for appointment of a Medical Review Panel;
- Arrange the appointment of panelists;
- Submit questions to a panel relating to matters in section 61(1) of the *Act*;
- Prepare a statement of foundational non-medical facts where the Board or a panel considers that such is necessary to determine a medical dispute;
- Receive Medical Review Panel certificates, and send copies to the appropriate participants in the appeal process.

In addition the Board provides support staff who assist panel chairmen in preparing files for examination by the panel and arranging the examinations of workers by the panel. Finally, the cost of examinations is payable out of the accident fund as part of the administrative expenses of the Board.

Because of the fact that the *Act* provides for independent panels, while at the same time mandating that the Board provide services within the Medical Review Panel process, it is essential that policies be published which define how the Board will perform its role in the Medical Review Panel Appeal process.

#103.20 Medical Review Panel Registrar

The performance of the administrative duties mandated by the *Act* is under the direction of a Medical Review Panel Registrar. While the Registrar is an officer of the Board, the Registrar does not report to the President and Chief Executive Officer but reports directly to the Board of Directors through the Chair of the Board of Directors. The Registrar manages a staff, which is known as the Medical Review Panel Department, and is in general responsible for the carrying out of the duties which the *Act* provides that the Board must carry out within the Medical Review Panel Appeal process. In addition the Registrar has responsibility for:

- advising the Board of Directors and implementing the policies of the board of directors on the administration of the Medical Review Panel process;
- coordinating the interaction and the distribution of information between the Board, the Chairmen and Specialist members and workers and employers, including the development and implementation of educational programs, quality assurance feedback, and complaints procedures;
- interacting with the Medical Committee appointed pursuant to section 58(2) of the *Act* regarding the maintenance of specialist lists, additions of new specialties, and other areas of mutual concern;
- preparing a Medical Review Panel annual report.

#103.21 Assistant Registrar/Medical Appeals Officers

The Medical Review Panel Department is staffed by an Assistant Registrar and Medical Appeals Officers. Medical Appeals Officers or the Assistant Registrar have authority to make initial decisions on preliminary matters. This includes decisions on:

- whether there is a medical decision or finding that can be appealed;
- whether the appeal is within time;
- whether a valid physician's certificate has been provided in support of the appeal;
- the contents of the Statement of Issues setting forth the questions for determination by the Medical Review Panel;
- the contents of statements of foundational non-medical facts when there is a need for such statements.

The Registrar may delegate other functions to the Assistant Registrar or Medical Appeals Officers.

#103.30 Access to the Medical Review Panel Process

a) Workers

Section 58(3) states:

> "A worker is entitled to be examined by a medical review panel if, not later than 90 clear days after the making of a medical finding by the review board or a medical decision by the board, the worker
>
> (a) writes to the board expressing that the worker is aggrieved by the medical finding or decision, and
>
> (b) sends with the writing a certificate from a physician certifying that, in the physician's opinion, there is a bona fide medical dispute to be resolved, and stating sufficient particulars to define the question in issue."

b) Employers

Section 58(4) states:

> "An employer or former employer of a worker is entitled to have the worker examined by a medical review panel if, not later than 90 clear days after the making of a medical finding by the review board or a medical decision by the board, the employer or former employer
>
> (a) writes to the board expressing that the employer or former employer is aggrieved by the medical finding or decision, and
>
> (b) sends with the writing a certificate from a physician certifying that, in the physician's opinion, there is or may be a bona fide medical dispute to be resolved, and stating sufficient particulars to define the question in issue."

c) Dependants of Deceased Workers

Section 63 of the *Act* states:

> "(1) A dependant of a deceased worker is entitled to have a medical review panel inquire into and determine the cause of death of the worker if the dependant writes to the board expressing that the dependant is aggrieved by a finding of the review board or a decision of the board concerning the cause of death."

An inquiry under section 63 can deal only with the cause of death. There is no ninety day time limit for requesting an inquiry under section 63 as there is for appeals under

section 58(3) or 58(4). A request for inquiry under section 63 need not be supported by a physician's certificate.

A Medical Review Panel Certificate issued pursuant to section 63 is conclusive as to the cause of death of the worker and is binding on the Board. This may create a conflict between the findings in a Medical Review Panel Certificate prepared while the worker was still alive (e.g. a Medical Review Panel may certify pursuant to section 58(3) that a worker does not have silicosis, and a Medical Review Panel may certify pursuant to section 63 that the same worker died of silicosis.) A Medical Review Panel Certificate issued pursuant to section 58(3) with regard to the claim by the worker is not binding with respect to a decision on a dependant's claim in respect of a worker's death, if following the death of the worker new medical evidence as certified to in the section 63 Medical Review Panel certificate is available.

d) The Workers' Compensation Board

Section 58(5) of the *Act* provides that "the board may decide that the worker must be examined by a medical review panel, in which case the worker must be so examined in the manner provided in this section."

This section enables the Board, at its discretion, to refer a worker to a Medical Review Panel. There is no time limit for the referral and the Board is not required to certify that there is a bona fide medical dispute to be resolved. The purpose of this section is to enable the Board to refer a worker to a Medical Review Panel where there are unusually difficult or complex medical questions which arise for decision as part of the normal decision making process.

The Board may also use its powers under section 58(5) to ensure that procedural difficulties related to the commencement of a Medical Review Panel appeal by workers or employers do not preclude access to the Medical Review Panel process for purely technical reasons. This is explained more fully in policy items #103.40 and #103.41 below.

The Board's authority under section 58(5) is not to be used to refer a worker to another Medical Review Panel because the Board or the worker or the employer disagree with the findings of a previous Medical Review Panel.

#103.40 Commencement of Appeal

An appeal to a Medical Review Panel may be brought from an initial decision in the Claims Department, a finding by the Review Board, or from an Appeal Division decision. Under sections 58(3) and 58(4), a request for an appeal to a Medical Review Panel by a worker or an employer must be made in writing and must be made not later than ninety clear days after the making of a medical finding by the Review Board or a medical decision by the Board.

To allow for mail delivery, the ninety day period under sections 58(3) and 58(4) does not commence until the tenth day following the date of the decision or finding (or the mailing date if that is separately stamped on the decision) under appeal. The Board will accept transmission of the written notice and the physician's certificate by fax machine.

Sections 58(3) and 58(4) require that both the appellant's application and a valid physician's certificate must be received within ninety days of the medical decision being appealed. The *Act* does not specifically permit the Medical Review Panel or the Board to extend the ninety day period for receipt of the documents. However, section 58(5) of the *Act* does not place any time limit on the Board to bring a matter before a Medical Review Panel. The Board is prepared in some situations to use its powers under section 58(5) to ensure that procedural difficulties related to the commencement of a Medical Review Panel by workers or employers do not preclude access to the Medical Review Panel process for purely technical reasons.

The Board's policy is that the Medical Review Panel Registrar will exercise the Board's authority under section 58(5) to have the worker examined by a Medical Review Panel where an appeal does not meet the strict requirements of sections 58(3) and 58(4) but there has been substantial compliance with the requirements. The policy is that substantial compliance occurs when:

(a) one document is received within the ninety day period allowed by sections 58(3) and 58(4) and the other, usually the physician's certificate, within ninety days of the expiry of that period; or

(b) after a decision has been made within the initial ninety day period that the physician's certificate does not contain a bona fide medical dispute, a valid certificate is received within the balance of the initial period or within a period of ninety days from the end of the initial period; or

(c) after a decision has been made following the initial ninety days that the physician's certificate does not contain a bona fide medical dispute, a valid certificate is received within ninety days of the date of that decision.

#103.41 Certificate of Bona Fide Medical Dispute

Section 58(3) of the *Act* says that an appeal by a worker must be supported by a certificate issued by a physician, "certifying that, in the physician's opinion, there is a bona fide medical dispute to be resolved, and stating sufficient particulars to define the question in issue."

Section 58(4) of the *Act* says that on an appeal by an employer, the physician is required to certify only that there "is or may be" a bona fide medical dispute to be resolved.

The certifying physician has to provide sufficient particulars to define the question in issue. The physician does not have to provide further information to show, for example, that the physician's opinion is conclusively supported by general medical opinion.

The certificate must reflect the opinion of the certifying physician that there is a bona fide medical dispute. A certificate certifying the opinion of the worker, employer or any other person is not valid.

The certificate must be consistent with the non-medical findings of fact in the decision in which the medical finding is found which is being disputed.

Section 58 says that the certificate must be from a "physician" and section 1 of the *Act* defines physician to be "a person registered under the Medical Practitioners' Act." Because of the hardship this can cause if a worker has moved outside the province and is receiving care from a physician in another jurisdiction, this is another instance where the Board may use its authority under section 58(5) of the *Act* to refer a matter to a Medical Review Panel. The Board may refer a matter to a Medical Review Panel when the physician who signs the certificate is not registered under the Medical Practitioners' Act of British Columbia. The policies which govern the exercise of this discretion are as follows:

a) The worker or employer has met all the requirement for an appeal to a Medical Review Panel except that the certificate is signed by a physician from another jurisdiction;

b) The appellant has made a reasonable attempt to obtain a certificate from a physician licensed to practice in the Province of British Columbia;

c) The out of province physician is registered under the equivalent of the B.C. Medical Practitioners' Act for the jurisdiction in which he or she and the appellant both reside.

Any document signed by a physician that contains the necessary information may be accepted as a valid certificate. However, the Board does provide a form of certificate and it is recommended this form be used to minimize the chance of disputes over the adequacy of the certificate.

The Medical Review Panel Department has the responsibility to determine whether the certificate from the physician is adequate and that it certifies both that a bona fide medical dispute exists and states sufficient particulars to define the medical question in issue.

The initial decision regarding the adequacy of the certificate is usually made by a Medical Appeals officer in the Medical Review Department. If there is a dispute, the Registrar will, on a request being made in writing, review the decision of the Medical Appeals officer. If the Registrar affirms the Medical Appeals officer's decision this is a decision that can be appealed to the Internal Review Division.

#103.42 Assuming Jurisdiction

Workers' and employers' appeals must be from the "making of a medical finding by the Review Board or a medical decision by the Board" and it must be certified to by a physician that a "bona fide medical dispute" requires resolution.

The question of whether a decision is, or is not, a medical decision can be contentious. Policy cannot anticipate all the circumstances which would, or would not, constitute a medical decision, and no attempt will be made to do so.

However, one illustration will be made. The severity of a physical impairment and the impact it has on bodily function, including the ability to work, is a medical decision and can be appealed to a Medical Review Panel. However, the extent to which a particular impairment and the restriction of bodily function which results will impair the earning capacity of a worker is not a medical decision, and cannot be appealed to a Medical Review Panel.

The Board has specifically determined that an appeal to a Medical Review Panel is not available to employers who wish to appeal a decision made under section 39(1)(e) of the *Act*. The Board has determined that appeals to Medical Review Panels are confined to situations which affect the rights of workers to compensation, and such an appeal does not meet this test. The Board's position is fully explained in Decision 93 - 0389 of the *Workers' Compensation Reporter*.

Where there is a dispute about whether a proposed appeal deals with a medical decision, or whether a valid physician's certificate has been provided, it will be the responsibility of the staff of the Medical Review Panel Department to decide such issues. As these are decisions which have the effect of allowing or refusing to allow a worker or employer to have an issue resolved by a Medical Review Panel, if the dispute cannot be resolved between the worker or employer appellant and the Department these are decisions that can be appealed to the Internal Review Division.

#103.50 Selection of Medical Review Panels

Each Medical Review Panel consists of a Chairman and two Specialist members.

Section 58(1) provides:

> "The Lieutenant Governor in Council may appoint, on the terms and conditions the Lieutenant Governor in Council establishes, one or more chairs of medical review panels, and an acting chair, who may act as chair whenever a chair is unable to act."

Section 58(2) provides that "The Lieutenant Governor in Council must appoint a medical committee which must prepare a list of specialists in particular classes of injuries and disabilities in respect of which workers have claimed compensation, which list may be amended from time to time, . . ."

The committee consists of representatives of the College of Physicians and Surgeons and the B.C. Medical Association.

#103.51 Nomination and Appointment of Specialist Members

Section 59(1) provides:

> "On receipt of the expression in writing made under sections 58(3) or (4) or on a decision being made under section 58(5) the board must, within a reasonable period of time, by notice by registered mail, require the worker and the worker's employer each to nominate from the list mentioned above within eight days after receipt of the notice, one specialist in the particular class of injury or ailment in respect of which the worker has claimed compensation, . . ."

The appropriate specialty for each appeal is designated by the Registrar. A copy of the list of specialists in that specialty including a short biographical note on each specialist member, is then mailed to the worker and employer.

If the party who commenced the appeal fails to nominate a specialist within eight days after receipt of the notice, no further proceedings are taken on that appeal.

If the party other than the one who commenced the appeal fails or neglects to nominate a specialist within eight days after the receipt of the notice, the Minister must appoint a specialist as a member of the Panel, and that member is deemed to be appointed on the recommendation of that party.

In the event that the worker is:

(a) self-employed;

(b) the child, parent, brother, sister, husband or wife of the employer; or

(c) a partner in or member of the firm that is the employer

or the employer has ceased to carry on business in the industry in which the injury or disability occurred, the Board shall not require the employer to nominate a specialist but must itself nominate a specialist as if it were the employer. This nomination will be made by the Registrar on behalf of the Board.

The Board shall, within 18 days from the receipt of the nominations, if the specialists are prepared to accept the nominations, appoint the specialists members of a Medical Review Panel to examine the worker. The two specialists so appointed together with a Chairman are a Medical Review Panel.

#103.52 Medical Dispute Concerns Multiple Specialties

Both the worker and the employer must receive the same list of Specialist members. A Medical Review Panel cannot include different specialties.

Where the medical question in dispute is in a borderline area between specialties, the Registrar may:

- choose the specialty that is of primary relevance to the matter in dispute and send out the list for that specialty; or
- set up a separate Panel for each specialty under a common Chairman.

The alternative will be selected that provides the best method of resolving the medical dispute.

Where there is overlapping between physical and psychological complaints, there may be an issue whether, for example, orthopaedic surgeons or psychiatrists should be on the Panel. In determining this issue, the Registrar will consider whether:

- there is a significant dispute regarding the worker's physical condition to be resolved;
- the psychological aspects appear to be within the range of the ordinary consequences of injury normally dealt with by orthopaedic surgeons;
- there is a separate complex psychiatric problem that requires the expertise of psychiatrists.

Where only one Panel is selected, the Panel may be advised that it may obtain a consultation report from a specialist in the other area. Before the Panel reaches a decision, the Chairman may recommend that the Registrar set up a second Panel in a different specialty.

If a Panel is properly constituted, the validity of its certificate cannot be challenged on the basis that it dealt with a medical issue outside the specialty of the Panel members.

#103.53 Disqualification of Specialist

Section 59(1) provides that ".....no specialist may be a member of a medical review panel who

(a) examines workers on behalf of the employer;

(b) has treated the worker;

(c) has acted as a consultant in the treatment of the worker; or

(d) is a partner of, or practises medicine together with such specialist,

and there must not be on the same panel specialists who are partners or who practise medicine together."

The exclusion under clause (d) of a Specialist member who "is a partner of, or practices medicine together with such specialist, . . ." does not apply where the partnership or association no longer exists.

The exclusions in section 59(1) operate in addition to the common law rules of bias. This means that Specialist members are not permitted to sit on a Panel where they have a relationship with a person concerned in the claim which gives rise to a reasonable apprehension of bias. This includes relationships with other members of the Panel, and any other officer of the Board who may have been involved with the claim.

#103.54 Failure of Specialist to Accept Nomination or Complete Duties

If a specialist does not accept the nomination or if for any reason he or she is unable to complete the duties as a member of the Panel, another specialist is nominated and appointed in the manner set out in policy item #103.51 for the appointment of the specialists.

If the specialist's inability to complete the duties occurs after the worker has been examined by the Panel but before the issuance of the certificate, or before a necessary clarification or reconsideration of the certificate is required, a new examination will be conducted.

#103.60 Defining the Issues

The purpose of the Medical Review Panel process is to definitively resolve disputes and answer questions related to medical findings made by the Review Board or officers of the Board, including the Appeal Division.

The *Act* requires in section 61(1) that in each case brought to the Panel pursuant to section 58(3), 58(4), or 58(5), the Panel shall certify to the Board as to:

- the condition of the worker;
- the existence or non-existence of a disability;
- if there is a disability, its nature and extent, its cause, and if there is more than one cause, how much of the disability is related to each cause.

In addition, if a worker, though no longer disabled, claims to have had a longer period of disability than that previously allowed by the Board, the Panel shall certify whether the worker was disabled for a longer period than that allowed by the Board. If the Panel does certify that the worker was disabled for a longer period than that allowed by the Board, the Panel shall also certify for what longer period the worker was disabled and the nature and extent of the disability during the period beyond that previously allowed by the Board.

By virtue of their enumeration in section 61(1) and the fact that the *Act* requires the Panel to certify to the issues listed there, it is clear that decisions related to the matters identified in section 61(1) are medical decisions.

In an appeal brought pursuant to section 63, the Panel shall certify as to the cause of death of the deceased worker, and the cause of death is clearly a medical decision.

In addition to certifying to the issues enumerated in section 61(1), section 61(3) permits the Board to submit questions to the Panel relating to the matters enumerated in section 61(1), and states that the certificate of the Panel shall include answers to those questions.

To constitute a valid certificate whose findings are binding on the Board these questions and answers must relate to medical findings only. A Panel is not authorized by the statute to certify to anything other than medical findings. To the extent that a Medical Review Panel purports to certify to findings other than medical findings, those non-medical findings will be severed from the Panel's certificate, and will not be binding on the Board.

Problems related to whether a decision is a medical decision or not can be avoided by formulating precise questions for the Panel which state exactly the issues on which the medical decision of the Panel is sought. It is the responsibility of the Medical Review Panel Department to prepare these questions so that the Medical Review Panel can conduct its independent examination and provide a valid certificate.

For appeals which proceed under sections 58(3), 58(4) (and section 58(5) where the Board has exercised its discretion to overcome technical difficulties related to section 58(3) and section 58(4) appeals), the Medical Review Department will have in its possession an acceptable physician's certificate which has certified to the existence of a bona fide medical dispute and which has also provided sufficient particulars to define the question in issue. In such cases the usual practice of the Medical Review Panel Department will be to prepare a Statement of Issues asking the medical questions that the Board wants the Medical Review Panel to answer. Appended to the Statement of Issues will be the physician's certificate and a copy of the decision of the Review Board, Appeal Division, or Board officer, in which the disputed medical decision is found.

Where the Board considers that a statement of foundational non-medical facts is necessary to determine the medical dispute, the Medical Review Panel Department will prepare such a statement for the Panel. It is expected that only in unusual cases or where the request is under section 58(5) and there is no physician's certificate would such a statement be necessary.

When the Panel, after receiving the statement of issues, with appendices, considers a statement of foundational non-medical facts is necessary to determine the medical dispute, the Panel shall advise the Medical Review Panel Department what non-medical facts require determination in order for it to determine the medical dispute, and the Medical Review Panel Department will prepare such a statement.

The Statement of Issues, and the statement of foundational non-medical facts when one is required, will be sent to the parties participating in the appeal for comment prior to being sent to the Medical Review Panel Chairman.

When there is a dispute regarding the contents of either document a Medical Appeals Officer will attempt to resolve the dispute. If the dispute is not satisfactorily resolved the Registrar will, upon written request, review the Statement of Issues and/or the statement of foundational non-medical facts and make a final determination as to the contents of these documents. The appeal will then proceed to the Medical Review Panel.

Because the decision of the Registrar as to the contents of these documents has no bearing on whether the matter proceeds to the Medical Review Panel, the Board considers this decision to be an administrative decision and it cannot be appealed to the Internal Review Division.

The administrative nature of the decision refers only to the Medical Review Panel Department's authority to include or exclude already decided facts in the statement of foundational non-medical facts.

If the Medical Review Panel Registrar or Medical Review Panel identify, in order to determine the medical dispute before the Panel, the need for a decision on a non-medical fact that has not been decided by the Board, the Registrar will refer the issue to the Compensation Services Division of the Board for adjudication by the appropriate Board officer (e.g. Claims Adjudicator, Claims Adjudicator Disability Awards, etc.).

A decision will be communicated to the interested parties in the normal way, and being a new decision with respect to a worker, if there is a dispute there will be a right to request a review of the decision under section 96.1 of the *Act*. The Medical Review Panel process will await resolution of the dispute before proceeding further.

Given that under sections 58(3) and 58(4) the Medical Review Panel process requires a physician's certificate that certifies to the existence of a bona fide medical dispute and that provides sufficient particulars to identify the issue before the Medical Review Panel process can proceed, and that most Medical Review Panel appeals have already been through the Review Board and Appeal Division appeal process, it is expected that the need to make new findings of non-medical fact after the Medical Review Panel process has begun, will occur on only rare occasions.

#103.70 Examination by the Panel

Once the Medical Review Panel Department has completed its required preliminary duties the appeal is referred to the Chairman of the Medical Review Panel that will be conducting the examination in the case.

Section 60 of the *Act* provides that the Chairman of the Panel shall arrange for the examination of the worker, and for review of the records of the Board, by the Chairman and the other members of the Panel. While the Medical Review Panel Department staff may provide some administrative assistance in regard to these matters, this assistance will be at the direction of the Panel Chairman.

In conducting the examination the Medical Review Panel operates independently of the Board and its Medical Review Panel Department. The Board, including the Medical Review Panel Department, has no authority to instruct the Panel about the way it reviews the medical evidence or conducts its examination of the worker.

If additional medical information is needed the Panel will make whatever arrangements it considers necessary to obtain the information. This includes having the worker examined by specialists in different areas of medical or other expertise than that of the Panel members. The Medical Review Panel Department will provide any administrative assistance requested by the Panel in making necessary arrangements.

Section 61 authorizes the Panel to determine its own procedure and to receive and accept the evidence that in its discretion it considers fit and proper and essential to resolving the medical issues before it. To enable the Panel to fully exercise this authority section 61 provides that the Chairman and other members of a Panel have the powers conferred on the Board by section 87 of the *Act*. These powers include the authority to compel the attendance of witnesses for examination under oath, and to compel the production and inspection of relevant documentary evidence.

While the Panel is independent of the Board, the Panel must comply with the provisions of the *Act*. For example, except in fatal cases, the *Act* requires that the Panel shall proceed by examination of the worker. The requirement that there be an examination of the worker means that an appeal cannot proceed if the worker dies before an examination takes place. If the worker dies before the examination takes place, the appeal to the Medical Review Panel will be discontinued. This does not affect the right of a dependent of a worker to appeal to a Medical Review Panel pursuant to section 63 with respect to the cause of the worker's death.

The requirement that an examination must take place applies equally to proceedings initiated by the worker, the employer, or the Board. The worker is therefore obliged to attend the examination when the proceeding is initiated by the employer or the Board. If the worker does not do so, any benefits being paid to the worker at the time which are relevant to the claim in dispute will be suspended. If the worker is not receiving benefits at the time the Medical Review Panel examination is requested, the worker will be

required to be examined by the Medical Review Panel before any reopening of the claim which relates to the medical issue in dispute can be considered.

#103.80 Certificate of the Panel

The ultimate responsibility following examination of the worker by the Panel is for the Panel to certify to the Board as to the matters referred to in section 61 of the *Act*. In order to achieve the aim of the Medical Review Panel process some ongoing dialogue between the Medical Review Panel Department and the Medical Review Panel may be necessary. For example, a Panel may find that it needs additional information before it can reach a decision. If additional conclusions of non-medical fact, or clarification of the questions being put to the Panel are needed, the Panel may refer the matter back to the Medical Review Panel Department.

On the other hand, if upon receipt of a certificate from the Panel the Medical Review Panel Department considers the certificate to be incomplete or ambiguous, the Medical Review Panel Registrar may refer the certificate back to the Medical Review Panel for clarification. This matter is discussed more fully in policy item #103.88 below.

The decision of a majority of the Panel is the decision of the Panel, and within a reasonable time after the examination of the worker the Chairman of the Panel shall certify to the Board in accordance with the requirements of section 61(1) of the *Act*.

Upon receipt of a Medical Review Panel certificate by the Board it will be the responsibility of the Board's officers to make adjudicative decisions based on the findings certified to in the certificate. The following determinations are set forth in policy in an attempt to avoid disputes about whether a Panel certificate certifies to medical findings, in which case it is binding on the Board, and to non-medical facts which are not properly part of a certificate.

#103.81 Condition of the Worker

The Board interprets the reference to the "condition of the worker" in section 61(1)(a) of the *Act* to refer to the physical or psychiatric condition related to the medical issue in dispute. It is not a reference, for example, to the economic condition of the worker. Where possible, when describing the condition of the worker, the Panel will state the medical diagnosis which accounts for the worker's condition.

#103.82 The Existence or Non-Existence of a Disability

There are two main issues that can arise under this heading. The first is the definition of disability. The second arises when, at the time of examination, the Panel finds that there is no disability.

The *Act* requires the Panel to certify as to the existence or non-existence of a disability. The *Act* does not define the meaning of the word disability. Disability is a word that can and does have many meanings, depending on the context in which it is used. In some contexts disability might refer simply to a physical or psychological impairment. In another context disability might refer simply to an economic impairment, for example impaired earning capacity. In most cases disability refers to the interaction between physical or psychological impairment, and external requirements, the most relevant in the workers' compensation context being the physical and mental requirements of a worker's occupation.

There is nothing in the *Act* to suggest that a Medical Review Panel should not describe the nature and extent of a disability in terms of its effect on a worker's capability to perform certain tasks, including work related tasks. Thus, although it would be an error for a Medical Review Panel to certify that a worker's disability caused a specified impairment of earning capacity it would not be an error for a Medical Review Panel to certify that a worker, based on the medical findings, appeared to be incapable of performing any "manual labour or sedentary labour."

Such a finding of a Medical Review Panel would still leave the responsibility for assessing the impaired earning capacity flowing from the Medical Review Panel finding of an inability to perform manual or sedentary labour to the appropriate Board officer. This would allow the Board officer to assess the extent to which alternate employment, alternate ways of doing the same employment, etc. would impact on the impaired earning capacity of the worker.

As regards the second issue, there will be times when the Panel does not find a disability upon examination. This may arise when the medical issue to be determined relates to an alleged disability from which recovery has occurred. To some extent this issue arises under section 61(1)(e) of the *Act*. But section 61(1)(e) refers only to the situation where the worker claims to have had, in the past, a longer period of disability than that recognized by the Board. There are times when it is not simply the worker's allegation of a longer disability than that recognized by the Board that will require the

Panel to be asked, if the disability does not exist at the time of examination, whether a disability ever did exist, and if so, what was its nature and degree.

In answering this question the Panel may arrive at a different medical conclusion than had previously been arrived at by Board adjudicators. If that occurs, because the Medical Review Panel certificate is binding on the Board, this will require adjustment of the previous decisions of the Board. Policy item #41.11 of this Manual provides an example of how the Board responds where a Medical Review Panel concludes that a disability that the Board had previously found to be non-compensable is caused by work related activity. Policy item #41.11 notes that such a certificate has retroactive effect.

The opposite situation can also arise, i.e. the Board's previous decision may have been that the condition was compensable and the decision of the Medical Review Panel is that the disability was not caused by work related activities. For example, a worker may appeal the question of whether a permanent disability has resulted from what the Board had determined to be a compensable injury. In answering questions relating to the existence, nature and extent, and cause of the disability, the Medical Review Panel may certify that the disability, which the Board had previously accepted as compensable, was not caused by work related activities. This is a medical decision, and one certified to, and is binding on the Board. Where this occurs the Board must terminate benefits, although, being a decisional error, there would be no retroactive application of the decision and an overpayment would not be declared (see policy item #48.41 of this *Manual*).

#103.83 Nature and Extent of a Disability

The problems that arise under this section are essentially the same as those which have been discussed in policy item #103.82 regarding the meaning of disability. However there is one further matter that requires comment. Section 61(1)(c) says that the Panel shall not state the nature and extent of a disability "in terms of percentage of disability of the body." A Panel certificate should therefore not certify that a worker has, for example, "a 100% of total" disability. Such a finding would be in conflict with the wording in section 61(1)(c). However a certification by the Panel that a worker has a "total" disability does not violate the letter of the law expressed in section 61(1)(c). While it could be argued that the phrase "total disability" means the same as the words "100% of total" and therefore certification that a worker had a total disability would be contrary to the intent, if not the letter, of section 61(1)(c), the policy of the Board is that in some circumstances, and if the cause of the "total disability" is determined to be caused by purely medical factors, it is acceptable for a Medical Review Panel to certify that "total disability" exists. This interpretation is the only one which would not interfere with the requirement of the *Act* that a Panel certify to the nature and extent of a disability.

Even a finding of "total disability" based on medical findings would still require consideration by the appropriate Board officer to determine whether there was a 100% impairment of earning capacity resulting from the disability. It is not within the

jurisdiction of a Medical Review Panel to certify directly that a permanent disability award is payable. The decision whether to award a permanent disability award requires consideration of employability factors other than the existence and degree of a disability.

#103.84 Cause of the Disability

Section 61(1)(d) of the *Act* requires the Panel to certify as to the cause of the disability. Cause is a word much like disability in that it has different meanings, depending on the context in which it is used. Sometimes it can refer to matters of natural science, sometimes to moral value judgements, and sometimes to questions of law. The purpose of the Medical Review Panel is to provide an appeal from "a medical decision of the Board" and it is in that context that the word "cause" must be interpreted. The Board interprets the word cause in section 61(1) of the *Act* to refer to the etiology of a physical or psychological disability. It means cause insofar as it is a matter of medical science, but not cause insofar as it is a matter of moral value judgements, or law, or non-medical fact.

Analysis of the issues that can arise in the adjudication of whether a work caused disease is compensable illustrate the distinction between a medical cause and a legal cause.

Whether a disease is an occupational disease as contemplated by the *Act* is a question of law. An occupational disease is either a disease listed in Schedule B of the *Act*, or such other disease that the Board, by regulation of general application, or by order dealing with a specific case, may recognize as being an occupational disease.

The diagnosis of a disease and the conclusion that the disease was due to the nature of any employment in which the worker was employed is a medical question.

Compensation is payable, pursuant to section 6(1) of the *Act*, only for occupational disease. Therefore a Medical Review Panel finding that a disease was due to the nature of the worker's employment would not create entitlement or benefits unless the disease was already one mentioned in Schedule B or had been recognized by regulation or order as an occupational disease.

It would be proper for the Medical Review Panel to certify that as a question of medical science, a disease was caused by the worker's employment. However, such a finding would say nothing about entitlement to benefits and the Panel would be going beyond its jurisdiction if it certified that such a disability was an "occupational disease" because that would be a conclusion of law.

However the policy of the Board is that where a Medical Review Panel certifies that a disease is due to the nature of the worker's employment, and that disease has not previously been designated as an occupational disease, the Board will designate, for

the purpose of that worker's claim, that that disease is an occupational disease and compensation benefits will then be paid as warranted.

#103.85 Duration of Disability

The problems that can arise in the interpretation of section 61(1)(e) of the *Act* have previously been discussed in policy items #103.82 and #103.83 of this *Manual*.

#103.86 Certificate Binding on the Board

Section 65 provides that a properly constituted certificate which certifies to a medical decision of a Medical Review Panel is conclusive as to the matters certified to and is binding on the Board. Any subsequent decision of the Board at any point in time, must be consistent with the certificate. For example, a Board officer in the Compensation Services Division could not decide, e.g. even 10 years after a Panel certificate was issued stating there was no disability, that the worker had a disability, if there was no change in the medical evidence upon which the Medical Review Panel certificate was based. However, a Medical Review Panel certificate is binding on the Board only to matters as they stand at and prior to the date of the certificate. A decision by a Medical Review Panel that a worker has no disability could be followed by a decision of the Board officer made a week after the Medical Review Panel decision that the worker had a disability if there was evidence that a new disability had arisen on the same claim after the Medical Review Panel had issued its certificate. Similarly it is open to the Board to make a decision as to the nature and extent of disability of a worker after a certificate is issued without being bound by the terms of that certificate if there is evidence that the worker's condition has changed, so long as that decision is not inconsistent with the original Medical Review Panel certificate.

#103.87 Narrative Report of the Panel

Section 61(2) of the *Act* provides that the Panel may, in addition to and separately from the certification required under section 61(1), make a report and recommendations to the Board on any matter arising out of the examination of the worker and the review of the medical records. The recommendations, even if they deal with medical issues alone, are not binding on the Board. Where the Panel does make such a report the Board shall promptly send a copy of the report to the physician whose certificate was sent to the Board under section 58(3) or 58(4).

Given the context in which section 61(2) appears, it is the Board's opinion that the primary purpose of a narrative report is to bring to the attention of the physician who provided the certificate under sections 58(3) or 58(4) matters of medical interest which "go beyond that required to be certified to in the certificate." The purpose of the narrative report, when one is prepared, is not to justify the conclusions that the Panel has in its certificate.

#103.88 Disputes Over Medical Review Panel Certificates

There are two levels at which disputes may arise about the Medical Review Panel certificate. The first level relates to whether the certificate is complete and whether it answers the questions placed before the panel and complies with the requirements of section 61(1) of the *Act*. The second level occurs when the Board officer is required to readjudicate the claim in light of the findings of the Medical Review Panel certificate.

The purpose of the Medical Review Panel Appeal process is to bring finality to disputed medical issues. The *Act* has provided for independent panels, but has also provided a role for the Board in the process. Both the Panels and the Board have the same interest - to ensure that Panels provide clear answers to questions related to medical findings and decisions made by the Review Board or Board officers. This mutual interest continues upon receipt of the Panel certificate.

If, in the opinion of the Medical Review Panel Registrar, the certificate has failed to answer the questions put to it, or has answered the questions in a way that is so unclear or inconsistent that the Panel decision cannot be ascertained, the Registrar may refer the certificate back to the Panel for clarification. The Registrar may not express opinions which would suggest disagreement with the findings, but only express opinions as regards the comprehensibility of the certificate. The Board considers that this role for the Medical Review Panel Registrar is justifiable given the responsibility that will ultimately rest on the Board to readjudicate the claim in accordance with the medical findings in the certificate. The Panel has an unfettered authority to respond to the requests for clarification in the way it sees fit. It may make changes in response to the request for clarification or it may consider that no clarification is necessary or desirable.

Section 61(7) of the *Act* provides that within eighteen days of receipt of the certificate or such further time that the Board considers necessary, the Board shall review the claim

and send a true and complete copy of the certificate to the worker, to the physician whose certificate accompanied the request under section 58(3) or (4), and to the employer.

Disputes related to the certificate which arise in the course of the Board's readjudication of the claim in light of the certificate's findings will be resolved through the normal appeal process.

#103.90 Miscellany

#103.91 Fishing Industry

The *Fishing Industry Regulations* provide special rules for claims by fishers.

Regulation 10(3) provides that, for the purpose of appealing to a Medical Review Panel, the employer in respect of a fishing vessel owned or chartered by a commercial buyer or other commercial recipient of fish is the vessel owner or charterer. The employer in respect of a fishing vessel not owned or chartered by a commercial buyer or other commercial recipient of fish is

(a) the vessel master; or

(b) the vessel owner; or

(c) any commercial buyer or other commercial recipient of fish; or

(d) any other person required to pay assessment under Regulation 5; or

(e) such other person or association of employers; as may be designated by the Board for these purposes.

#103.92 Disclosure and the Freedom of Information and Protection of Privacy Act

Policy items #99.00 to #99.90 of this *Manual* set forth the general policy of the Board concerning the disclosure of information on a worker's file.

Requests for information that do not fall within the general disclosure policy are dealt with pursuant to the *Freedom of Information and Protection of Privacy Act.* For the purpose of that Act, Medical Review Panel records are under the authority of the British Columbia Ministry of Skills Development and Labour. The Ministry of Skills Development and Labour and the Workers' Compensation Board have entered into a formal protocol respecting disclosure of Medical Review Panel records. The protocol stipulates that the purpose of the protocol is to enable the Ministry and the Board to

fulfill their respective obligations concerning Medical Review Panels pursuant to the *Freedom of Information and Protection of Privacy Act ("FIPP").* The significant relevant parts of the protocol are as follows:

- The records created by Medical Review Panels are the responsibility of the Ministry for purposes of FIPP. Such records include the certificate, narrative reports, submissions to the Medical Review Panel, notes pertaining to the examination of the worker, and notes pertaining to the writing of the narrative. All other Medical Review Panel related records are administrative in nature and fall within the Board's purview for the purposes of FIPP.

- In the event of a request by the individual to whom the certificate pertains, the certificate will always be disclosed.

- In the event of requests by the individual to whom the narrative report pertains, the Ministry has delegated authority to the Medical Review Panel Department of the Board to release that report except in cases where the narrative report contains medical information, the release of which, in the opinion of the Medical Review Panel Department, could harm the individual to whom the report pertains.

- In the event that the Medical Review Panel Department does conclude that harm might result from release of the narrative report, the Medical Review Panel Department shall refuse access and inform the requester that he or she has a right to make a formal Freedom of Information request through the offices of the Information and Privacy Manager of the Ministry.

- Requests for notes pertaining to the examination of the worker and the writing of the narrative report shall not be dealt with in accordance with the Board's disclosure policy. They shall always be dealt with under formal Freedom of Information requests which should be submitted to the Information and Privacy Manager of the Ministry.

- The Medical Review Panel Department will assist the Information and Privacy Manager of the Ministry by helping individuals fill out Information and Privacy request forms and by expeditiously providing information and records to the Information and Privacy Manager of the Ministry as directed.

- All other requests by individuals for administrative records of the Medical Review Panel Department which pertain to those individuals will be disclosed to them in accordance with the normal disclosure policies of the Board by the Medical Review Panel Department.

- All requests for Medical Review Panel information by third parties shall be refused in the normal course of business. All Freedom of Information requests by third parties for Medical Review Panel created information shall be directed to the Information and Privacy Manager of the Ministry. The

Medical Review Panel Department will assist those parties in making such requests.

- All Freedom of Information requests by third parties for Medical Review Panel administrative records shall be directed to the FIPP coordinator of the Board.

The protocol specifically says that nothing in the protocol precludes disclosure where such disclosure is required by law, i.e. under the authority exercised by courts or tribunals.

#103.93 Expenses

The Medical Review Panel Department may award expenses to persons attending Medical Review Panels in accordance with policy items #100.00 to #100.70 of this *Manual*.

RE: Reviews and Appeals – Transitional Matters Relating to the Review Board and Appeal Division

ITEM: C13-104.00

BACKGROUND

1. Explanatory Notes

The Explanatory Notes to Item C13-100.00 set out the general changes to the workers' compensation appeal system made by the *Workers Compensation Amendment Act (No. 2), 2002* ("*Amendment Act (No. 2), 2002*") effective March 3, 2003. Except for purposes of addressing certain matters covered by the transitional provisions of the *Amendment Act (No. 2), 2002*, the Workers' Compensation Review Board and the Board's Appeal Division ceased to exist as of that date.

The transitional provisions continue the appointments of members of the Workers' Compensation Review Board past March 3, 2003, for purposes of making decisions in certain cases. Those cases are proceedings where the Review Board has completed an oral hearing, or has received final written submissions and begun its deliberations. The members who have been involved in those cases are authorized, sitting as the Review Board, to complete their decisions.

The transitional provisions also continue the appointments of Appeal Commissioners of the Appeal Division past March 3, 2003, for purposes of making decisions in certain cases. Those cases are proceedings where the Appeal Division has completed an oral hearing, or has received final written submissions and begun its deliberations. The Appeal Commissioners who have been involved in those cases are authorized, sitting as the Appeal Division, to complete their decisions.

Policy items #102.00 to #102.51 and #104.00 to #105.40 set out in the Appendix to Item C13-104.00 immediately following are required to enable proceedings of the Review Board and the Appeal Division under the transitional provisions of the *Amendment Act (No. 2), 2002* to be continued, completed and implemented in accordance with the transitional provisions.

2. The Act

Section 38 of *Amendment Act (No. 2), 2002*, in part:

> (3) If, in a proceeding pending before the review board on the transition date, the review board has
>
> (a) completed an oral hearing, or

(b) received final written submissions and begun its deliberations,

the review board must continue and complete those proceedings, acting with the same power and authority that the review board had under the Act before the provisions of the Act granting that power and authority were repealed by the amending Act.

(4) The appointments of the members of the review board who are sitting on proceedings described in subsection (3) are continued until those proceedings are completed.

Section 39 of the *Amendment Act (No. 2), 2002*, in part:

(4) If, in a proceeding pending before the appeal division on the transition date, the appeal division has

(a) completed an oral hearing, or

(b) received final written submissions and begun its deliberations,

the appeal division must continue and complete those proceedings, acting with the same power and authority that the review board had under the Act before the provisions of the Act granting that power and authority were repealed by the amending Act.

(5) The appointments of the appeal commissioners who are sitting on proceedings described in subsection (4) are continued until those proceedings are completed.

POLICY

Policy items #102.00 to #102.51 and #104.00 to #105.40 set out in the Appendix to Item C13-104.00 immediately following are continued in relation to proceedings of the Review Board and the Appeal Division on and after March 3, 2003, insofar as they are consistent with the *Workers Compensation Amendment Act (No. 2), 2002*.

PRACTICE

For any relevant PRACTICE in relation to proceedings of the Review Board and the Appeal Division on and after March 3, 2003, readers should consult the Workers' Compensation Appeal Tribunal.

EFFECTIVE DATE:	March 3, 2003
AUTHORITY:	*Workers Compensation Amendment Act (No. 2), 2002*
CROSS REFERENCES:	Reviews and Appeals - General (C13-100.00)
HISTORY:	New Item made necessary because of the *Workers Compensation Amendment Act (No. 2), 2002*
APPLICATION:	

APPENDIX TO ITEM C13-104.00

WORKERS' COMPENSATION REVIEW BOARD, WCB APPEAL DIVISION AND ANCILLARY IMPLEMENTATION ISSUES

#102.00 THE WORKERS' COMPENSATION REVIEW BOARD

Section 90(1) provides that:

> "Where an officer of the Workers' Compensation Board makes a decision under this *Act* with respect to a worker, the worker, or, if deceased, the worker's dependants, or the worker's employer, or a person acting on behalf of the worker, the dependants or employer, may, not more than 90 days from the day the decision is communicated to the worker, dependants or employer, or within another time the review board allows, appeal the decision to the review board in the manner prescribed by the regulations."

The application of this section to commercial fishers is dealt with in *Fishing Industry Regulations* 10 and 5 (found *in Workers' Compensation Reporter* Decision No. 223 as amended by Decision 225).

Regulations governing the procedure of the review board are found in B.C. Reg. 32/86.

The Workers' Compensation Review Board was formerly known as the board of review.

#102.10 Composition of Review Board

Section 89(2) provides that:

> "The review board must consist of
>
> (a) a chair,
>
> (b) one or more vice chairs, and
>
> (c) members the Lieutenant Governor in Council considers necessary who must be selected in equal numbers from persons having backgrounds associated with employer interests and persons having backgrounds associated with worker interests,

all of whom must be appointed by the Lieutenant Governor in Council."

#102.11 Chairman

Regulation 2 provides:

"(1.) The chairman has responsibility for the general administration of the review board and may

(a) appoint a registrar, and if he deems necessary a deputy registrar, from among its members,

(b) assign duties he considers advisable to the members, designate the matters in which they shall act, the place where they shall act and supervise the carrying out of their duties,

(c) subject to any agreement made under section 93(4) of the *Act*, employ such staff and make such provision for facilities and equipment as he considers necessary for the efficient operation of the review board,

(d) assign the duties he considers advisable to the staff of the review board and supervise the carrying out of their duties, and

(e) determine the type of records to be kept of the proceedings of the review board.

(2.) The chairman may designate a vice chairman to be acting chairman during his absence and the acting chairman will have all the powers and authority of the chairman."

#102.12 Panels

Regulation 3 provides in part as follows:

"(1.) The chairman shall

(a) establish panels of the review board;

(b) appoint members to the panels to ensure composition in the manner set out in subsection (2),

(c) terminate appointments made and fill vacancies, and

(d) assign appeals to the panels.

(2.) A panel shall be composed of

(a) the chairman or a vice chairman as presiding member and 2 other members, one of whom shall have a background associated with employer interests and one of whom shall have a background associated with worker interests,

(b) the chairman as presiding member and 2 vice chairmen; or

(c) the chairman or a vice chairman sitting alone.

(3.) The chairman may reassign any appeal from one panel to another before evidence is taken on the appeal by the panel to which it was originally assigned."

Section 89(7) of the *Act* states:

"The finding of a majority of a panel of the review board is a finding of the review board, but if there is no majority, the finding of the person presiding over the panel is a finding of the review board."

#102.13 Person Ceasing to be a Member

Regulation 3 also provides:

"(4.) Where a person ceases to be a member, he may, with the approval of the chairman, carry out and complete any duties or responsibilities and continue to exercise any powers that he may have had if he had not ceased to be a member in relation to a specific proceeding in which he participated.

(5.) Where a member is unable to complete his duties or responsibilities on a panel, the chairman may

(a) appoint a member, including himself, to replace that person,

(b) direct that the remaining persons comprising the panel constitute a quorum for the determination of an appeal, and that the findings of the quorum shall be the decision of the panel, or

(c) exercise his authority under subsection (3)" above.

#102.14 Registrar

Regulation 4 provides:

> "(1.) At the direction of the chairman, the registrar shall be responsible for determining all administrative matters pertaining to the filing of and completion of an appeal before the review board and shall carry out the following duties:
>
> (a) supervise staff assigned to him by the chairman;
>
> (b) review all appeals filed with the review board to determine their compliance with section 90 of the *Act* and these regulations;
>
> (c) correspond with parties to an appeal to ensure compliance with the requirements for pursuing a valid appeal and to suspend appeals where these requirements are not met after due notice to the affected party;
>
> (d) ensure that all issues raised by an appeal have been disposed of before the claim file is returned to the board;
>
> (e) refer claim files to an officer of the board where a matter under appeal has not been considered in the first instance."

Regulation 5, Subsection (5) provides:

> "The registrar shall acknowledge receipt of every appeal made to the review board and provide a copy to the respondent together with a notice of appearance."

#102.20 Decisions Which May Be Appealed

The review board has jurisdiction where an officer of the Board makes a decision under the *Act* with respect to a worker.

Thus, the first requirement is that there must be a decision to appeal from. Sometimes complaints are received that no decision has been made. In other words, the complaint concerns delay. A complaint of this kind would not normally be a matter for the review board. If the Adjudicator does not respond to the complaint, it should be referred to the Unit or Area Office Manager.

#102.21 Administrative Matters

Decisions of a purely administrative nature are not subject to the appeal system. Any complaint on a matter of administration should be addressed to the departmental Director.

As an example, "C" had been awarded compensation in 1956 as a foster-mother in respect of her three children. In 1973, the youngest child attained the age of 18 years, and the remaining benefits attributable to the children were terminated. Subsequently, the compensation payable to "C" was also terminated. "C" complained, and the complaint was processed as an appeal to a board of review. It is clear, however, that the board of review had no jurisdiction. There was no complaint about any claims decision made within the preceding 90 days. The only new decision made by the Pensions Clerk was that the youngest child had reached the age of 18 years, and there was no dispute about that. The consequential termination of benefits to "C" on that event was not a "decision" made by the Pensions Clerk but simply an administrative act implementing a decision made in 1956.

While the review board has jurisdiction over the question whether a worker has been overpaid by the Board and the amount of any overpayment, it has no jurisdiction over whether the Board should collect that overpayment from the worker or over the manner of collection.

#102.22 Jurisdictional Matters

A question on the application of Part 1 or other jurisdictional questions that may have implications beyond the particular claim should be referred to the Vice-President, Compensation Services Division, as soon as it is recognized, whether before or after the initial claims decision. This would apply if, for example, the issue is whether the employer for which the worker worked was covered under Part 1, or whether the worker was a worker.

Where a decision on the claim has already been made by an Adjudicator and the worker is appealing to the review board, there is a statutory right to appeal to the review board, and the appeal cannot at that stage be diverted by reference to the Vice-President. The value of a reference before the initial claims decision is to have the Vice-President consider whether some general directive is required on the jurisdictional question that would relate to claims generally.

#102.23 Claims by Dependants

The *Act* refers to appeals by dependants with regard to a decision made with respect to a worker. This includes decisions made with respect to a deceased worker.

#102.24 Discretionary Matters

Various sections of the *Act* confer on the Board discretionary powers with regard to compensation, for example, sections 17(14), 17(16), 32(1), 32(3), 35(1) and 35(2).

These discretionary powers are exercised in various ways. If the situation is one that rarely occurs, the matter is sometimes referred to the Vice-President, Compensation Services Division, for a decision. An example of this category is the recognition of an occupational disease in a particular case.

For situations that arise more frequently, the normal practice is for there to be established guidelines, and for the decisions to be made by the Adjudicators. Here again, if a new situation arises on which no guidelines have been established, the matter can be referred to the Vice-President, Compensation Services Division, for direction.

The question now being considered is whether an appeal lies to the review board from the decision of an Adjudicator on one of these discretionary matters.

In this connection, there are two views commonly taken of the role of an appellate tribunal.

1. The substitutional role. On this view, the role of the appeal tribunal is to substitute its judgment for that of the person making the initial decision. This is the role of the review board on issues of right. Subject to the terms of the *Act* and the decisions and practice established by the Governors, the review board may, on a question of right, substitute its own judgment for that of the Adjudicator.

2. The supervisory role. On this view, the role of the appellate tribunal is not to substitute its judgment for that of the initial Adjudicator; but rather to ensure simply that a decision has been properly made. In other words, the role of the review board is to intervene when a decision is wrong, but not to substitute a different judgment when there is no error. That is the role of the review board on a discretionary issue. The *Act* does not delegate to the review board all the functions of the Board, nor does it confer on the review board an authority to exercise a discretion that is conferred upon the Board. Rather it confers upon the review board a supervisory appellate jurisdiction to ensure that when the discretion is exercised by an officer of the Board, it is properly exercised.

Thus, a decision of an officer of the Board on a discretionary matter relating to compensation may be appealed to the review board. But where there is such an appeal, the question for the review board is whether the decision was wrong, and it is not wrong simply because, if the review board were responsible for deciding

the matter, it would have exercised the discretion differently. In other words, the decision of the Adjudicator should be returned for reconsideration of the discretion where the review board concludes that:

1. The conclusions of fact on which the discretion was exercised were not correct,

or

2. The Adjudicator had departed from the terms of the *Act*, or from previous directives or decisions of the Governors relating to the exercise of discretion.

But where there is no such objection to the decision, there is no error for correction.

#102.25 Disability Awards

Though disability awards do require the exercise of some discretion in making assessments, a worker's permanent disability award entitlement to a permanent disability award is fundamentally a question of right. The limitations on the appellate role which apply in the case of discretionary matters are not appropriate to disability awards. Therefore, as with any other appeal on a matter of right, the review board has full jurisdiction over permanent disability awards.

Where the review board has expressed dissatisfaction with the manner of assessment for a disability award and has recommended reassessment and re-evaluation, the Board will implement that decision to the extent of carrying out that re-evaluation as is discussed in policy item #102.51. However, should the result be no increase in the disability award, the worker's avenue of appeal is back to the review board or to a Medical Review Panel. A decision of a Board officer with respect to a worker cannot be appealed directly to the Appeal Division.

#102.26 Rehabilitation Matters

Rehabilitation is a discretionary matter for the Board. There is no legal right to rehabilitation. However, appeals are permitted on other discretionary matters. Therefore, subject to the principles set out in policy item #102.24 regarding appeals on discretionary matters, the review board has jurisdiction to consider appeals on rehabilitation matters.

Not everything a Rehabilitation Consultant does is appealable to the review board. That right only exists in respect of "decisions". Routine actions of communicating in writing, by telephone or in person with workers, union representatives, employers, or other persons for the purpose of finding suitable

employment for a worker do not normally involve an appealable decision. If a worker is dissatisfied with this aspect of a Rehabilitation Consultant's work, there will normally be an allegation concerning a lack of action or delay on the part of the Consultant or be complaining that the Consultant is not in some other way doing the job. This is a complaint of an administrative nature which should be directed to the Consultant's Manager or departmental Director.

Generally speaking, a Rehabilitation Consultant will only make a decision appealable to the review board when making a decision to grant, terminate or refuse some specific rehabilitation service. Some examples are decisions to:

1. Grant or not grant retraining, or as to the type of retraining for which the Board should be responsible;

2. Pay or not pay personal care allowances, independence and home maintenance allowances and homemakers' services;

3. Modify or not modify a worker's automobile, home, or workplace;

4. Make or not make grants to assist the worker in establishing a business;

5. To pay or not pay job search allowances.

In addition to those specific matters, there would also be an appeal to the review board against a decision to refuse to provide or discontinue rehabilitation assistance in general.

There is another area where, though the Rehabilitation Consultant may be considered to be making a decision, no separate appeal to the review board lies. This is where the Rehabilitation Consultant is making an assessment or investigation for the Claims Adjudicator, Disability Awards Officer or Adjudicator in Disability Awards and makes a recommendation to them which will assist them in making a decision. Examples are the assessments carried out when a decision has to be made on:

1. A worker's entitlement to wage-loss benefits under section 30 of the *Act* for a temporary partial disability;

2. A worker's entitlement to a permanent disability award on a projected loss of earnings basis;

3. An application for a commutation.

In each of those situations, the final decision is made by a Claims Adjudicator, Disability Awards Officer or Adjudicator in Disability Awards and their decision, not the recommendation of the Rehabilitation Consultant which led to it, is appealable to the review board. Of course, the review board may consider the

merits of the Consultant's recommendation when considering the appeal against the decision of the Claims Adjudicator, Disability Awards Officer or Adjudicator in Disability Awards.

Before proceeding with an appeal, the worker may ask that the matter in dispute be discussed with the appropriate Rehabilitation Manager.

#102.27 Decisions Affecting the Worker Financially

The limiting words "with respect to a worker" mean that the decision under appeal must be a claims decision involving an issue of a kind or class that affects workers financially.

The review board has no jurisdiction if the issue in dispute is simply one of cost allocation among employers, or among classes of employers.

It may be helpful to illustrate the point with some examples.

1. If the dispute is whether the present disability results from an injury occurring in one year with employer "A", or in another year with employer "B", the result may affect the worker financially, and the review board therefore has jurisdiction.

2. If the issue is whether the present disability is attributable to an injury occurring in one year with the particular employer or in another year with the same employer, it may affect the worker financially, and so the review board has jurisdiction.

3. If there is no dispute that the disability is attributable to an injury occurring on a particular date, but there is an issue on whether "A" or "B" was the employer of the worker on that date, the result makes no difference to the worker financially if both employers were covered by the *Act*. Thus, if the issue is simply to which sector fund the cost of the claim should be assigned, the review board would have no jurisdiction.

4. If an employer is making an application under section 39(1)(d) or (e) for the sector or rate group fund to be relieved of part of the cost of a particular injury; that is not a matter that makes any difference to the worker, and is not a matter within review board jurisdiction.

5. If an employer has been charged with compensation costs under section 54(8) and is applying for relief under section 54(9) then that is not an issue that makes any financial difference to the worker, and as such it is an issue on which the review board have no jurisdiction.

If the issue is of a class or kind which affects the worker financially, review board jurisdiction is not excluded because that may not be the employer's motive, or because another result will be to shift the cost of a claim or part of it from one employer to another or from one sector or rate group to another.

#102.28 Decisions of Medical Appeals Officers

A decision of a Medical Appeals Officer allowing or refusing to allow a worker or employer to appeal to a Medical Review Panel is appealable to the review board.

#102.30 Commencement of Appeal

#102.31 Time Limits

Section 90(1) provides in part that the appeal must be made ". . . not more than 90 days from the day the decision is communicated to the worker, dependants or employer, or within another time the review board allows, . . ."

Any request for an extension of time for appealing to the review board should be referred to the review board. The worker or employer wishing to appeal should be invited to state the reasons for delay, or the reasons for extending the time. The reasons can be mentioned in the notice of appeal, or in a separate letter, or if the person enquiring so wishes, the reasons can be recorded by the Adjudicator receiving the enquiry.

#102.32 Initiation of Appeal

Regulation 5 provides as follows:

> "(1.) An appeal to the review board shall be filed at its office or at an office of the board.
>
> (2.) An appeal shall
>
> (a) be in writing signed by the appellant or his agent,
>
> (b) specify the decision being appealed and state why, in the opinion of the appellant, the decision is incorrect, and
>
> (c) set out the remedy sought.
>
> (3.) Where the grounds of appeal relate to evidence that was apparently not considered by or disclosed to the officer of the board, the written appeal must contain

(a) the names and addresses of any witnesses to be produced,

(b) a description of any documentary evidence to be offered, and

(c) if the evidence is additional medical evidence, a short statement as to how the evidence will affect the decision under appeal.

(4.) If subsections (2) and (3) are not fully complied with, the review board may require the appellant to file with it a completed notice of appeal in the form determined by the review board.

(5.) The registrar shall acknowledge receipt of every appeal made to the review board and provide a copy to the respondent together with a notice of appearance.

(6.) A respondent, who wishes to participate in the appeal, shall file the notice of appearance with the registrar within 21 days from the date of dispatch of the notice under subsection (5)."

Section 90(2) of the *Act* provides that:

> "Where the employer of a worker referred to in subsection (1) has ceased to be an employer within the meaning of Part 1, the review board may, for the purposes of an appeal under subsection (1), deem an organized group of employers which includes as members employers in the subclass of industry to which the employer belonged to be the employer of the worker."

#102.40 Conduct of Appeal

Section 89(6) of the *Act* provides that:

> "Subject to any regulations made under subsection (5), the review board may conduct an appeal in the manner it considers necessary, and it is not required to hold an oral hearing."

Regulation 6, Subsection (2) provides:

> "The review board shall consider relevant information and argument submitted to it by or on behalf of a worker, employer or dependant, whether made orally or in writing."

Regulation 8, Subsection (2) provides:

> "Subject to the *Act*, all reasonable time limits set by a panel for the due conduct of an appeal shall be complied with unless waived by the chairman or the panel."

#102.41 Board Files

Regulation 6, Subsection (6) provides:

> "The review board has the right to examine an original or copy of a record in the board's possession that relates to a matter under appeal."

Regulation 8, Subsection (1) provides:

> "All records of the review board, other than personal notes kept by a member, shall be delivered to the board following the finding of the review board."

#102.42 Oral Hearings

Section 89(6) provides that:

> "Subject to any regulations made under subsection (5), the review board may conduct an appeal in the manner it considers necessary, and it is not required to hold an oral hearing."

Regulation 6, Subsection (1) provides:

> "Where the review board does not conduct an oral hearing, it shall permit parties to the appeal to make written submissions."

Where the review board decides to hold an enquiry, it may arrange travel schedules to conduct enquiries in various cities and towns of the province.

Transcripts of tape recordings of review board hearings are not provided. After the review board has rendered its finding, copies of the tape recordings may be obtained from the Disclosure Section, through the normal disclosure process. Requests for copies of a tape prior to that time must be directed to the review board.

#102.43 Powers of Investigation

The review board has all the powers conferred on the Board by section 87.

Regulation 6, Subsections (3) and (4) provide:

> "(3.) The review board may require and receive medical or other evidence and information on oath, affidavit or otherwise as in its discretion it considers proper to make a fair decision.
>
> (4.) The review board may require a worker to attend for examination by a physician chosen by the review board."

Payment for services rendered under Regulation 6, Subsections (3) and (4) are made at the rates paid by the Board for similar services.

#102.45 Disclosure of Information

Regulation 6, Subsection (5) provides:

> "The review board shall, in determining whether or not a record in its possession, including a medical report, should be disclosed to a worker, employer or other person, follow the practice of the board."

#102.46 Expenses

For the Board's general rules on expenses incurred by workers or employers, reference should be made to policy item #100.00.

Regulation 7, Subsections (1) and (2) provide:

> "(1.) The review board may order the board to reimburse a person for the cost incurred in
>
> (a) attending an oral hearing,
>
> (b) obtaining a medical report submitted to the review board, or
>
> (c) attending an examination required under section 6(4).
>
> (2.) The amount of costs authorized under subsection (1) shall not exceed the rates paid by the board for similar services."

#102.50 Referral of Review Board Findings

Every finding of the review board, together with its reasons, shall be recorded in writing and promptly sent to the appellant and the employer or worker or the dependants as the case may be and to the Workers' Compensation Board.

The review board finding will initially be reviewed by a Board officer. The Board officer will, without delay or further investigation, implement the review board finding in accordance with policy item #105.30.

If the Board officer feels that one or both of the following two grounds of referral exist, he or she will discuss the review board finding with his or her Manager:

1. The finding contains an error of law.

2. The finding contains a contravention of a published policy of the Governors.

If the Manager agrees with the Board officer, the Board officer will prepare a memo to the Vice-President, Compensation Services Division, outlining how the referral grounds are met.

By way of explanation, the first ground means that the finding is contrary to the provisions of the *Act* or based upon some other clear error of law. The second ground means that the finding contradicts the published policy of the Governors. The published policy of the Governors is set out in policy item #96.10 of this manual.

If the referral is to be made on the first ground, the referral memo should contain a reference to the section of the *Act* or provision of law that the finding contradicts. If the referral is to be made on the second ground, the referral memo should contain a reference to the section of the *Rehabilitation Services and Claims Manual* or other published policy of the Governors that the finding contradicts. A referral on either ground should provide full particulars and an explanation as to how the referral ground is met.

A copy of the referral memo and a copy of the review board finding which is the subject of the referral is to be sent to the Vice-President. If the Vice-President considers it necessary to review the entire claim he or she will request it.

The referral memo to the Vice-President must be sent without further investigation and within two weeks of the date the review board finding was received by the Board. If the Vice-President considers that the grounds of referral are met and that the matter should be referred to the Appeal Division for redetermination, he or she will refer the matter to the President. The President will make the final decision as to whether to refer the review board finding to the Appeal Division under section 96(4).

If the President determines that the grounds of referral are met, and that the matter should be referred to the Appeal Division under section 96(4), the worker, employer, and any other interested party will be notified by letter that the finding has been referred to the Appeal Division for redetermination under section 96(4). This letter of notification will include copies of the referral memo written by the

Board officer. After the notification letter is sent out, the claim will be referred to the Appeal Division.

The issue of the implementation of a review board finding where a referral is made by the President is dealt with in policy item #105.30.

Where the Medical Review Panel Registrar identifies a decision that relates to the administration of the Medical Review Panel Department, and where the decision is based on an error of law or is made in contravention of published policy of the Governors, the Registrar may refer the Review Board finding directly to the President without the necessity of first referring the matter to the Vice-President, Compensation Services Division.

#102.51 Implementation of the Workers Compensation Review Board's Finding Directing Reassessment or Reconsideration

It commonly happens that, instead of reaching a specific finding on a matter, the review board will direct that the Compensation Services Division reassess or reconsider something, for example, a permanent partial disability award. The review board finding is properly implemented if the reassessment or reconsideration is carried out even if the conclusion reached is the same as the one which was previously appealed to the review board. However, if the Claims Adjudicator, Disability Awards Officer, Adjudicator in Disability Awards or Rehabilitation Consultant implementing the review board finding is the same one who made the original decision against which the appeal was made, and if that person's decision is still negative, the matter is to be referred to a second Claims Adjudicator, Disability Awards Officer, Adjudicator in Disability Awards or Rehabilitation Consultant for a second look. If a difference of opinion results from the second look, the decision of the second Claims Adjudicator, Disability Awards Officer, Adjudicator in Disability Awards or Rehabilitation Consultant will prevail.

Where, in addition to directing the reassessment or reconsideration, the review board makes some specific findings of fact, for example, that the worker was unable to carry out certain jobs, the Compensation Services Division is bound by those findings.

Where the reassessment or reconsideration results in no change in the original Compensation Services Division decision, an appeal lies back to the review board or, if the decision involves a medical issue, to a Medical Review Panel.

#104.00 THE APPEAL DIVISION

The jurisdiction of the Appeal Division is set out in specific sections of the *Workers Compensation Amendment Act*, 1989, as outlined below. In addition, the Governors have designated certain other matters as appealable to the Appeal Division under section 96(6.1) and delegated the authority of the Board in certain matters to the Chief Appeal Commissioner and the Appeal Division.

#104.10 Appeals from Review Board Findings

Section 91 provides that where the review board makes a finding under section 90, the worker, the worker's dependants, the worker's employer or the representative of any of them may, not more than 30 days after the finding is sent out, or within a longer period the Chief Appeal Commissioner may allow, appeal the finding to the Appeal Division.

The employer of a fisher for purposes of an appeal to the Appeal Division is discussed in *Fishing Industry Regulations* 10 and 5 (found in *Workers' Compensation Reporter* Decision 223 as amended by Decision 225).

#104.20 Referrals of Review Board Findings

Section 96(4) provides that the President may, not more than 30 days after a finding of the review board is sent out, refer the finding to the Appeal Division for redetermination on grounds of error of law or contravention of published policy of the Governors.

#104.30 Reconsideration of Appeal Division Decisions

Section 96.1 provides that a worker, the worker's dependants, the worker's employer or the representative of any of them may apply to the Chief Appeal Commissioner for reconsideration of a decision of the Appeal Division on the grounds that new evidence has arisen or has been discovered subsequent to the hearing of the matter decided by the Appeal Division.

Where the Chief Appeal Commissioner considers that the evidence is substantial and material to the decision and did not exist at the time of the hearing, or did exist at that time but was not discovered and could not through the exercise of due diligence have been discovered, the Chief Appeal Commissioner may direct that the Appeal Division reconsider the matter or that the applicant may make a new claim to the Board with respect to the matter.

Section 17 of the *Workers Compensation Amendment Act* provides that a worker, the worker's dependants, the worker's employer or the representative of

any of them may apply to the Chief Appeal Commissioner for reconsideration of a decision made under section 91 or 96 of the former *Act* on the same grounds and in the same manner as that set out in section 96.1 of the new *Act*. This means that the Appeal Division also has the jurisdiction to reconsider decisions of the former Commissioners in accordance with the reconsideration provisions of section 96.1.

The Appeal Division of the Workers' Compensation Board of British Columbia shall exercise the authority of the Workers' Compensation Board of British Columbia under section 96(2) of the *Act* to reopen, rehear and redetermine any decision made by the former Commissioners prior to June 3, 1991, where the Chief Appeal Commissioner finds that the decision was based upon an error of law or involved or involves an issue under the *Canadian Charter of Rights and Freedoms*.

#104.40 Employer Appeals

Section 96(6) provides that an employer who has received notice of an assessment under section 39 or 40, a classification, special rate, differential or assessment under section 42, or an additional assessment, levy or contribution under section 73 may, not more than 30 days after receiving the notice or within a longer period the Chief Appeal Commissioner may allow, appeal the assessment, classification, special rate, differential or additional assessment, levy or contribution to the Appeal Division on the grounds of error of law or fact or contravention of a published policy of the Governors. The published policy of the Governors is set out in policy item #96.10.

In Decision #4 of the Governors, under section 96(6.1), the Governors have designated that an employer who has received notice relating to an assessment, classification, monetary penalty or apportionment or shifting cost between classes for which no appeal to the Appeal Division is specifically provided in section 96(6) may appeal to the Appeal Division.

Under these sections, the Appeal Division has jurisdiction to consider appeals from the following decisions:

1. a decision to impose an additional assessment with respect to occupational safety and health matters under section 73;

2. a decision to impose an additional assessment with respect to first aid matters under section 70;

3. a decision on any assessment matter;

4. a decision with respect to the application of section 39(1)(d) or 39(1)(e);

5. a decision with respect to the charging of claims costs under section 47(2);

There may be other decisions made under the *Act* which might fall under the provisions of section 96(6) or 96(6.1). If an employer considers that a decision has been received for which an appeal is provided by section 96(6) or designated by the Governors under section 96(6.1) which is not listed above, the employer should raise the matter with the Appeal Division who will determine whether the Appeal Division has jurisdiction to hear the matter.

#104.50 Criminal Injuries

Section 12(a) of the *Workers Compensation Amendment Act* amends section 22(3) of the *Criminal Injury Compensation Act* such that by leave of a criminal injury appeal committee or the Chief Appeal Commissioner, the Appeal Division has jurisdiction over an appeal from a decision of a criminal injury appeal committee.

#104.60 Delegations to the Appeal Division

In Decision #4 of the Governors, the following authority of the Board is assigned to the Appeal Division by the Governors:

> "The Governors assign to the Chief Appeal Commissioner and the Appeal Division:
>
> 1. The Board's obligation to issue certificates under section 11;
>
> 2. The Board's authority to reallocate claims costs between employers under section 10(8);"

#105.00 PAYMENT OF CLAIMS PENDING APPEALS

#105.10 Appeals to the Workers Compensation Review Board – New Claims

The general practice is that no payment is made on a new claim until there has been an adjudication that the claim is valid.

When a decision is made to allow a claim that has been protested by an employer, the employer will be advised of the decision and reasons, where possible by telephone, and given an opportunity to provide any additional information. This is similar to the requirement in policy item #99.10 that a worker be advised if the indication on a claim is that it may be disallowed. If the decision

remains that the claim should be allowed, payments will be commenced immediately and a letter explaining the decision and reasons will be sent to the employer. The letter will advise the employer of their rights of appeal.

An employer can appeal up to 90 days from the decision allowing a claim.

If the review board reverses the decision of the Claims Department to allow the claim, payments are immediately terminated but no attempt is made to recover payment incorrectly made to the worker, unless there was evidence of fraud or misrepresentation. The employer's sector or rate group will be relieved of the claim costs pursuant to policy item #113.10.

#105.20 Appeals to the Workers Compensation Review Board – Reopening of Old Claims

If a decision is made to reopen an old claim, the employer is advised in writing. If the employer objects to this decision, they will be advised of their rights of appeal.

If the review board reverses the decision of the Claims Department to reopen the claim, payments are immediately terminated. No attempt is made to recover payments incorrectly made to the worker unless there was evidence of fraud or misrepresentation. The employer's sector or rate group will be relieved of the claim costs pursuant to policy item #113.10.

#105.30 Implementation of Review Board Findings

Section 92 provides as follows:

> "(1) Where a claim is allowed by the review board, periodic payments must commence, and a lump sum under section 17(13) must be paid; and an amount so paid is not, in the absence of fraud or misrepresentation, recoverable from the worker or dependants.
>
> (2) Notwithstanding subsection (1), where a finding of the review board is appealed under section 91 or reopened or reheard under section 96, payment of any compensation that has not yet been paid with respect to the period prior to the finding of the review board must be deferred until the date on which the appeal division makes its decision or redetermination under section 91 or 96, as the case may be.
>
> (3) If the appeal division decision is in favour of the worker or his dependants, interest

(a) calculated in accordance with the policies of the governors, and

(b) beginning 31 days after the date on which the review board made its finding or beginning on an earlier day determined in accordance with the policies of the governors must be paid on compensation that has been deferred under subsection (2)."

The procedures for implementing all review board findings are as follows:

1. Any benefits payable from the date of the review board finding forward will be paid without delay.

2. Any benefits payable for the period of time prior to the date of the review board finding (retroactive benefits) will be paid after 30 days have elapsed following the date of the review board finding unless:

   (a) the President has referred the review board finding to the Appeal Division under section 96(4); or

   (b) an appeal has commenced from the finding under section 91.

3. If there is a referral to the Appeal Division by the President under section 96(4) or an appeal of the finding under section 91 retroactive benefits will not be paid until the Appeal Division has completed its consideration of the matter.

4. The decision of the Appeal Division will be implemented upon its receipt by the Board officer. The worker's entitlement to retroactive benefits which were deferred according to #3 above will then be determined in accordance with the decision of the Appeal Division.

5. Where retroactive benefits are payable, after the decision of the Appeal Division, interest is to be paid in accordance with the Board's general policy on the payment of interest on retroactive benefits as set out in policy item #50.00. However, where no interest is payable under policy item #50.00 because it is determined that the retroactive benefit was not necessitated by a blatant Board error, interest will be paid beginning 31 days after the date on which the review board made its finding. The amount of interest to be paid is to be calculated in accordance with the interest rates set out in policy item #50.00.

The implementation of review board findings which result in a lump-sum payment or commutation is discussed at policy item #45.61.

#105.40 Appeals to a Medical Review Panel

Where the Appeal Division allows a worker's appeal, payment of benefits is commenced even if the employer appeals that decision to a Medical Review Panel or requests the Appeal Division to reconsider their decision.

RE: Changing Previous Decisions – General **ITEM: C14-101.01**

BACKGROUND

1. Explanatory Notes

The *Act* provides the following mechanisms by which the Board may change its decisions:

- reopenings;
- reconsiderations;
- reviews; and
- setting aside for fraud or misrepresentation.

More information about these mechanisms is presented in the Items C14-102.01 - C14-105.01.

2. The Act

See Items C14-102.01 - C14-105.01.

POLICY

This policy clarifies the types of decisions that do not constitute a reconsideration or a reopening of a previous decision.

(a) New matters not previously decided

The need to adjudicate new matters not previously decided and make decisions on these matters may occur at various points during the adjudication of a claim. The limits in the *Act* on the Board's ability to change previous decisions through a reconsideration or a reopening are not intended to restrict the Board's ability to make new decisions in accordance with the *Act* and policy that do not question previous decisions.

Situations in which the Board may make a new decision on a matter not previously decided may generally include, but are not limited to the following:

- Initial entitlement to temporary or permanent disability benefits;

- Acceptability of additional medical conditions identified during the adjudication of a claim or acceptability of further injury or disease that arises as a consequence of a work injury;

- Sections of the *Act* which give the Board broad discretion to make decisions regarding entitlement at various times over the course of a claim. In applying these provisions, a Board officer may consider a new matter that arises as a result of new information or a change in circumstances that occurs after a previous decision. Two examples are health care and vocational rehabilitation benefits.

    - Health care benefit entitlement – Section 21 of the *Act* enables the WCB to approve health care treatment and services to aid in a worker's recovery from the compensable injury or occupational disease. Consideration for health care benefits may occur at various points during the claim as the nature and severity of the worker's compensable injury or occupational disease changes and/or there is a determination that additional treatments or services will assist in the worker's recovery.

      Decisions regarding entitlement to health care benefits made as new matters arise, such as a change in the worker's medical condition, do not constitute a reconsideration of a previous decision. However, in any case where there is a request to retroactively change a past decision or the Board officer reconsiders a prior decision regarding health care, the restrictions on reconsideration apply.

    - Vocational rehabilitation benefit entitlement – Consideration of entitlement to vocational rehabilitation services under section 16 may be required at various points during the claim to assist in recovery and return to work.

      A decision to modify, replace or discontinue a rehabilitation plan is a new decision. Any subsequent decision regarding the worker's future entitlement to vocational rehabilitation services would also be a new decision with prospective application.

- A new matter may arise as a result of legislative provisions that expressly direct the WCB to make certain decisions or take certain actions at specified points in the claim. If the WCB fails to render these decisions or take these actions at the specified point, the Board officer must make the decision as soon as the error is discovered in order to fulfill the requirements of the *Act*. These decisions would have prospective application. For example, under section 33.1(2) of the *Act*, if a worker's disability continues for ten cumulative weeks of benefits, the WCB must determine the amount of average earnings of the worker based on the worker's gross earnings for the 12-month period immediately preceding the date of the injury.

(b) Implementation of Review Division Decisions or WCAT Decisions

On a review or an appeal, the Review Division and the WCAT may make a decision that confirms, varies or cancels the decision under review or appeal. The Review Division and WCAT decisions are final and must be complied with by the Board.

Varying or canceling a decision may make invalid other decisions that are dependent upon or result from the decision under review or appeal.

The reconsideration and reopening requirements under section 96 do not limit changes to previous decisions that are required in order to fully implement decisions of the Review Division or the WCAT.

PRACTICE

There is no PRACTICE for this Item.

EFFECTIVE DATE:	January 1, 2005
AUTHORITY:	ss. 96(2) - (7), *Workers Compensation Act*
CROSS REFERENCES:	Changing Previous Decisions - Reopenings (C14-102.01), Changing Previous Decisions - Reconsiderations (C14-103.01), Changing Previous Decisions - Fraud and Misrepresentation (C14-104.01), Changing Previous Decisions - Reviews (C14-105.01)
HISTORY:	Amendments effective January 1, 2005 to clarify the difference between a new decision and a change in a previous decision, and to provide guidance on the correction of errors, slips and omissions. New Item consequential to the *Workers Compensation Amendment Act (No. 2), 2002*
APPLICATION:	Applies to all decisions on and after January 1, 2005

RE: Changing Previous Decisions – Reopenings **ITEM: C14-102.01**

BACKGROUND

1. Explanatory Notes

The Board may, at any time, reopen a matter that has been previously decided by the Board or an officer or employee of the Board, if certain circumstances exist.

2. The Act

Section 96 states, in part:

.....

(2) Despite subsection (1), any time, on its own initiative, or on application, the Board may reopen a matter that has been previously decided by the Board or an officer or employee of the Board under this Part if, since the decision was made in that matter,

(a) there has been a significant change in a worker's medical condition that the Board has previously decided was compensable, or

(b) there has been a recurrence of a worker's injury.

(3) If the Board determines that the circumstances in subsection (2) justify a change in a previous decision respecting compensation or rehabilitation, the Board may make a new decision that varies the previous decision or order.

.....

POLICY

(a) General

The reopening of a previous decision does not affect the application of the decision to the period prior to the significant change in the worker's medical condition or the recurrence of the worker's injury. Rather, it enables the Board to reopen matters previously decided and determine a worker's ongoing entitlement. A reopening involves the adjudication of new matters.

(b) A reopening is not a reconsideration

A reopening is to be distinguished from a reconsideration of a previous decision.

A reconsideration occurs when the Board considers the matters addressed in a previous decision anew to determine whether the conclusions reached about these matters reached were valid. Where the reconsideration results in the previous decision being varied or cancelled, it constitutes a redetermination of those matters.

(c) Grounds for reopening

A decision may be reopened if, since it was made:

- there has been a significant change in a worker's medical condition that the Board has previously decided was compensable; or

- there has been a recurrence of a worker's injury.

"A significant change in a worker's medical condition that the Board has previously decided was compensable" means a change in the worker's physical or psychological condition. It does not mean a change in the Board's knowledge about the worker's medical condition.

A "significant change" would be a physical or psychological change that would, on its face, warrant consideration of a change in compensation or rehabilitation benefits or services. In relation to permanent disability benefits, a "significant change" would be a permanent change outside the range of fluctuation in condition that would normally be associated with the nature and degree of the worker's permanent disability.

A claim may be reopened for repeats of temporary disability, irrespective of whether a permanent disability award has been provided in respect of the compensable injury or disease. A claim may also be reopened for any permanent changes in the nature or degree of a worker's permanent disability.

(d) Recurrence of injury

A recurrence of an injury may result where the original injury, which had either resolved or stabilized, occurs again without any intervening new injury. A recurrence of an injury may result in a claim being reopened for:

- an additional period of temporary disability benefits where no permanent disability award was previously provided in respect of the compensable injury; and

- an additional period of temporary disability benefits where a permanent disability award was previously provided in respect of the compensable injury.

An example of a recurrence of an injury is where a worker has a compensable injury for which temporary disability benefits are paid. The injury resolves and the claim is closed, but later becomes disabling again without any intervening new injury. In these situations it is considered that the original injury has recurred. The result is that the worker may be entitled to an additional period of temporary and/or consideration for permanent disability compensation under the original claim.

A recurrence of injury that entitles a worker to request a reopening of an existing claim is to be distinguished from a new injury that entitles the worker to make a new claim.

For example, where a compensable injury is aggravated by a second compensable injury, the first injury has not "recurred". Rather a new injury has occurred that will result in a new claim. The decision whether to reopen the existing claim or initiate a new claim will depend upon the evidence in each case.

The following types of questions may assist in determining whether there is a recurrence or a new injury:

- Have there been any intervening incidents, work-related or otherwise?
- Has there been a continuity of symptoms and/or continuity of medical treatment?
- Can the current symptoms be related to the original injury?

(e) Reopening on application or on own initiative

Section 96(2) sets out the two ways in which the Board may reopen a matter that has been previously decided by the Board: on its own initiative, or on application.

A request for a reopening of a previous decision will be considered on application where the worker refers specifically to section 96(2) of the *Act* or uses language substantially similar to that section. An application may be submitted to the Board in written or verbal form.

A reopening request will not be considered on application where:

- a worker makes a general request for additional wage-loss benefits, health care benefits, vocational rehabilitation services or permanent disability benefits;
- a worker makes a request for a reconsideration and/or the acceptance of a new injury or occupational disease;
- a request is made by a person other than the worker, employer or their authorized representative;
- information is submitted to the Board such as medical reports received from a worker's doctor; or

- the Board has made a decision to reopen a matter on its own initiative as part of the ongoing adjudication of a claim.

(f) Right to request a review

Section 96.2(2)(g) of the *Act* provides that no request may be made to a review officer under section 96.2(1) to review a decision to reopen or not to reopen a matter on an application for a reopening under section 96(2). Section 240(2) provides that a decision to reopen or not to reopen a matter on an application may be appealed directly to the Workers' Compensation Appeal Tribunal ("WCAT").

The effect of these provisions is that the preliminary or threshold question whether the grounds for a reopening on an application have been met under section 96(2)(a) and (b) may not be the subject of a review by a review officer. A party who wishes to dispute the Board's decision in this respect must appeal directly to the WCAT.

However, where a reopening consideration was undertaken on the Board's own initiative, a request for review of the decision is made to a review officer.

Once it is determined that the grounds for a reopening have been met, the Board's decision on the compensation or rehabilitation to be paid or provided as a result of the reopening may be the subject of a request for a review by a review officer under section 96.2(1). The review officer's decision may then be appealed to the WCAT under section 239(1).

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	August 1, 2006
AUTHORITY:	ss. 96(2), (3), *Workers Compensation Act*
CROSS REFERENCES:	Changing Previous Decisions - General (C14-101.01), Changing Previous Decisions - Reconsiderations (C14-103.01), Changing Previous Decisions - Fraud and Misrepresentation (C14-104.01), Changing Previous Decisions - Reviews (C14-105.01)
HISTORY:	Consequential amendment to section (d) of policy resulting from changes to policy item #1.03 *Scope of Volumes I and II in Relation to Benefits for Injured Workers* of the *Rehabilitation Services & Claims Manual* Volume II made effective August 1, 2006. Amendments effective January 1, 2005 to clarify reopenings on application and on own initiative and to clarify recurrence of injury. Amendments effective March 18, 2003 to clarify that a reopening allows compensation or rehabilitation benefits to be "varied" and that disputes over a decision to reopen or not to reopen a matter "on application " are appealable directly to WCAT under section 240(2). New Item consequential to the *Workers Compensation Amendment Act (No. 2), 2002* approved effective March 3, 2003.
APPLICATION:	Applies to all decisions on and after January 1, 2005

RE: Changing Previous Decisions – Reconsiderations **ITEM: C14-103.01**

BACKGROUND

1. Explanatory Notes

The *Act* provides the Board with a very limited time period to reconsider previous decisions or orders. Subject to certain restrictions, the Board may only reconsider a decision or order under Part 1 of the *Act* during the period of 75 days subsequent to the decision or order being made.

2. The Act

Section 1, in part:

> **"reconsider"** means to make a new decision in a matter previously decided where the new decision confirms, varies or cancels the previous decision or order

Section 96, in part:

.....

(4) Despite subsection (1), the Board may, on its own initiative, reconsider a decision or order that the Board or an officer or employee of the Board has made under this Part.

(5) Despite subsection (4), the Board may not reconsider a decision or order if

(a) more than 75 days have elapsed since that decision or order was made,

(b) a review has been requested in respect of that decision or order under section 96.2, or

(c) an appeal has been filed in respect of that decision or order under section 240.

.....

POLICY

(a) Definition of reconsideration

A reconsideration occurs when the Board considers the matters addressed in a previous decision anew to determine whether the conclusions reached were valid. Where the reconsideration results in the previous decision being varied or cancelled, it constitutes a redetermination of those matters.

(b) The purpose of sections 96(4) and (5)

The Board's authority to reconsider previous decisions and orders is found in section 96(4) and (5) of the *Act*. These provisions result from legislative amendments that came into effect on March 3, 2003. The purpose of these amendments is to promote finality and certainty within the workers' compensation system.

The same amendments establish a right to request a review by a review officer under sections 96.2 to 96.5, where a party disagrees with a decision or order made at the initial decision-making level. It is this review, rather than the application of the Board's reconsideration authority, which is intended to be the dispute resolution mechanism for initial decisions and orders of Board officers.

It is significant that section 96(4) only authorizes the Board to reconsider a decision or order "on its own initiative". This is to be contrasted with the Board's authority to reopen a matter "on its own initiative, or on application" under section 96(2). It is also to be contrasted with section 96.5 and section 256, which authorize a review officer and the appeal tribunal, respectively, to reconsider decisions on application in certain circumstances.

The use of the words "on own initiative" in section 96(4), with no provision for "on application", and the availability of a review mechanism under sections 96.2 to 96.5, indicate that the Board is not intended to set up a formal application for reconsideration process to resolve disputes that parties may have with decisions or orders.

Rather, the Board's reconsideration authority is intended to provide a quality assurance mechanism for the Board. The Board is given a time-limited opportunity to correct, on its own initiative, any incorrect decisions it may have made.

(c) Advice to parties

Parties to a decision or order will be advised, in writing, at the time the decision or order is made, of the right to request a review of the decision or order under section 96.2. A party who approaches the Board to have the decision or order reconsidered will be reminded of the party's right to request a review under section 96.2. If the Board reconsiders a decision or order before the request for review is made, the Board will

advise the parties to the decision or order of the reconsidered decision. The reconsidered decision gives rise to a new right to request a review under section 96.2.

(d) Restrictions on reconsideration

The *Act* places a number of express restrictions on reconsidering previous decisions and orders. It is noted, in this respect, that "reconsider" means the making of the new decision and not merely the starting of the reconsideration process leading to the new decision.

- The Board may not reconsider a decision or order more than 75 days after the decision or order was made. This includes all decisions of the Board and officers and employees of the Board made prior to March 3, 2003. The 75 day period commences on the date the decision was made (not March 3, 2003 in the case of those decisions made prior to that date).

- The Board may not reconsider a decision or order if a review has been requested in respect of that decision or order under section 96.2. A request for review under section 96.2 immediately terminates the authority of the Board to reconsider a previous decision or order, even if 75 days has not passed since the decision or order was made.

- The Board may not reconsider a decision or order if an appeal has been filed in respect of that decision or order under section 240. The filing of an appeal under section 240 immediately terminates the authority of the Board to reconsider the decision or order, even if 75 days has not passed since the decision or order was made.

There are, in addition, a number of implicit restrictions on reconsidering previous decisions and orders. The Board is not authorized to reconsider decisions or findings of the following bodies:

- the former Appeal Division, which existed prior to March 3, 2003;
- the former Commissioners, who existed prior to June 3, 1991;
- the boards of review and the Workers' Compensation Review Board, which existed prior to March 3, 2003; and
- the Board of Review, which existed prior to January 1, 1974.

Section 256 of the *Act* provides for the Workers' Compensation Appeal Tribunal to reconsider its own decisions and decisions of the former Appeal Division under certain limited conditions. The Legislature therefore "turned its mind" to the extent that former appellate decisions should be reconsidered and legislated its intent.

(e) Grounds for reconsideration

Subject to the limitations set out above, the Board may reconsider a decision on its own initiative where:

- there is new evidence indicating that a prior decision or order was made in error;
- there has been a mistake of evidence, such as:
  - material evidence was initially overlooked, or
  - facts were mistakenly taken as established which were not supported by any evidence or by any reasonable inference from the evidence;
- there has been a policy error such as:
  - applying an applicable policy clearly incorrectly, or
  - not applying an applicable policy; or
- there has been a clear error of law, such as a failure by the Board to follow the express terms of the *Act*.

(f) Authority of Board officers, Managers and Directors to reconsider

A Board officer may only reconsider a decision made by another Board officer where there is new evidence, a mistake of evidence, a policy error or a clear error of law.

A Manager or Director may reconsider a decision or order made by a Board officer in any of these circumstances, and may also reweigh the evidence and substitute his or her own judgment for that of the Board officer.

(g) Correction of administrative errors

The correction of an administrative error such as a clerical, typographical or mathematical error or an error in an agreed statement of facts does not result in a reconsideration of a previous decision. The ability to correct these types of errors, slips or omissions would not be considered a reconsideration of the original decision, as it would not change the intent of the original decision made by the Board officer.

The limits on reconsiderations of previous decisions do not prevent a Board officer from issuing an addendum to correct a clerical or typographical error in a decision. This may be done where the text of the decision did not correctly reflect the Board officer's intent. An example of a clerical error might include a Board officer incorrectly typing in a decision letter $25,000 rather than $52,000 for a worker's earnings, but it is clear from the evidence on the claim that this was a simple typographical error.

An accidental slip or omission may occur when the decision as recorded does not clearly reflect the intention of the decision-maker. For example, a decision letter states "I do accept the degenerative changes as part of the claim", however; the remainder of the letter and the evidence on the claim clearly illustrate that the Board officer intended that the letter state "I do not accept".

This process for correcting errors, slips or omissions, however, cannot be applied to change decisions.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WCB website.

EFFECTIVE DATE:	January 1, 2005
AUTHORITY:	ss. 96(4), (5), *Workers Compensation Act*
CROSS REFERENCES:	Changing Previous Decisions - General (C14-101.01), Changing Previous Decisions - Reopenings (C14-102.01), Changing Previous Decisions - Fraud and Misrepresentation (C14-104.01), Changing Previous Decisions - Reviews (C14-105.01)
HISTORY:	Amendments effective January 1, 2005 to include policy on the correction of administrative errors. New Item consequential to the *Workers Compensation Amendment Act (No. 2), 2002*
APPLICATION:	Applies to all decisions on and after January 1, 2005

RE: Changing Previous Decisions – Fraud and Misrepresentation **ITEM: C14-104.01**

BACKGROUND

1. Explanatory Notes

Section 96(7) allows the Board to set aside any decision or order under Part 1 that has resulted from fraud or misrepresentation.

2. The Act

Section 96, in part:

> (7) Despite subsection (1), the Board may at any time set aside any decision or order made by it or by an officer or employee of the Board under this Part if that decision or order resulted from fraud or misrepresentation of the facts or circumstances upon which the decision or order was based.

POLICY

In order for a decision or order to be set aside as a result of misrepresentation, there must be more than innocent misrepresentation.

The misrepresentation must have been made, or acquiesced in, by the worker, dependant, employer or other person with evidence to provide, knowing it to be wrong or with reckless disregard as to its accuracy, and the decision or order must have been made in reliance on the misrepresentation. Misrepresentation would include concealing information, as well as making a false statement.

PRACTICE

For any relevant PRACTICE information, readers should consult the Rehabilitation and Compensation Services Division's Practice Directives available on the WCB website.

EFFECTIVE DATE: March 3, 2003
AUTHORITY: s. 96(7), *Workers Compensation Act*
CROSS REFERENCES: Changing Previous Decisions - General (C14-101.01), Changing Previous Decisions - Reopenings (C14-102.01), Changing Previous Decisions - Reconsiderations (C14-103.01), Changing Previous Decisions - Reviews (C14-105.01)

HISTORY: New Item consequential to the *Workers Compensation Amendment Act (No. 2), 2002*

APPLICATION: Applies to all decisions on and after March 3, 2003

RE: Changing Previous Decisions – Reviews **ITEM: C14-105.01**

BACKGROUND

1. Explanatory Notes

Sections 96.2 to 96.5 provide a right of review in respect of certain decisions made by Board officers.

2. The Act

Section 96, in part:

> (6) Despite subsection (1), the Board may review a decision or order made by the Board under this Part or by an officer of employee of the Board under this Part but only as specifically provided in sections 96.2 to 96.5.

POLICY

There is no POLICY for this Item.

PRACTICE

For any relevant PRACTICE information, readers should consult the Review Division's Practices and Procedures available on the WCB website.

EFFECTIVE DATE:	March 3, 2003
AUTHORITY:	s. 96(6), *Workers Compensation Act*
CROSS REFERENCES:	Changing Previous Decisions - General (C14-101.01), Changing Previous Decisions - Reopenings (C14-102.01), Changing Previous Decisions - Reconsiderations (C14-103.01), Changing Previous Decisions - Fraud and Misrepresentation (C14-104.01)
HISTORY:	New Item consequential to the *Workers Compensation Amendment Act (No. 2), 2002*
APPLICATION:	Applies to all decisions on and after March 3, 2003

CHAPTER 15

ADVICE AND ASSISTANCE

#109.00 INTRODUCTION

Workers or employers requiring advice or assistance on some aspect of a compensation claim are advised in the first instance to contact the Adjudicator, Claims Officer, or other Board officer dealing with it. For difficulties that are not resolved by this procedure, the Act has established Workers' Advisers and Employers' Advisers.

A worker or employer may also obtain advice and assistance from other sources, for example, trade unions, and employers' associations.

#109.10 Workers' Advisers

The duties of Workers' Advisers are to:

1. give assistance to a worker or to a dependant having a claim, except where a Workers' Adviser thinks the claim has no merit;

2. on claims matters, communicate with or appear before the Board or the Workers' Compensation Appeal Tribunal on behalf of a worker or dependant where an Adviser considers assistance is required; and

3. advise workers and dependants with regard to the interpretation and administration of the *Act* or any regulations or decisions made under it. (1)

A Workers' Adviser and staff shall have access at any reasonable time to the complete claims files of the Board and any other material pertaining to the claim of an injured or disabled worker; but the information contained in those files shall be treated as confidential to the same extent as it is so treated by the Board. (2)

EFFECTIVE DATE: March 3, 2003 (as to reference to the Workers' Compensation Appeal Tribunal)
APPLICATION: Not applicable.

#109.20 Employers' Advisers

The duties of an Employers' Adviser is to:

1. give assistance to an employer respecting any claim of

   (a) a worker, or

   (b) a dependant of a worker

   of that employer, except where an Employers' Adviser thinks the claim has no merit;

2. on claims matters, communicate with or appear before the Board or the Workers' Compensation Appeal Tribunal on behalf of an employer where an Adviser considers assistance is required; and

3. advise employers with regard to the interpretation and administration of the *Act* or any regulations or decisions made under it. (3)

An Employers' Adviser and staff have the same right of access to the Board's claim files as a Workers' Adviser and is subject to the same obligation of confidentiality. (4) In addition, section 94(5) specifically provides that "An employers' adviser must not report or disclose to an employer information obtained from or at the Board of a type that would not be disclosed to the employer by the Board."

EFFECTIVE DATE: March 3, 2003 (as to reference to the Workers' Compensation Appeal Tribunal)

APPLICATION: Not applicable.

#109.30 Ombudsman

The Ombudsman has the right to examine or copy material from claim files in the possession of the Board.

The Board regards the work of the Ombudsman's office as a forward step in the process of assuring fair and reasonable approaches to matters within the Board's jurisdiction. Full cooperation will therefore be extended to the staff of the Ombudsman's office in all matters.

NOTES

(1) S.94(2)
(2) S.95(3)
(3) S.94(3)
(4) S.95(3)

CHAPTER 16

THIRD PARTY / OUT-OF-PROVINCE CLAIMS

#110.00 INTRODUCTION

A worker who suffers injury or disease as a result of employment may be entitled to compensation from sources other than the Workers' Compensation Board. The Act makes special provision in Section 10 for injuries or diseases which occur in circumstances entitling the worker to pursue an action for damages against a third party.

Injuries occurring outside the province are not generally compensable. Where they are compensable, the Act makes special provision for cases where the worker is also entitled to claim compensation in the place of injury.

#111.00 THIRD PARTY CLAIMS

#111.10 Injury Caused by Worker or Employer

Section 10(1) of the Act provides that "The provisions of this Part are in lieu of any right and rights of action, statutory or otherwise, founded on a breach of duty of care or any other cause of action, whether that duty or cause of action is imposed by or arises by reason of law or contract, express or implied, to which a worker, dependant or member of the family of the worker is or may be entitled against the employer of the worker, or against any employer within the scope of this Part, or against any worker, in respect of any personal injury, disablement or death arising out of and in the course of employment and no action in respect of it lies. This provision applies only when the action or conduct of the employer, the employer's servant or agent, or the worker, which caused the breach of duty arose out of and in the course of employment within the scope of this Part."

This provision prohibits a law suit by an injured worker or a dependant of an injured worker against the employer of the worker or against any employer within the scope of Part 1 of the Act, or against any worker in respect of any personal injury, disablement, or death arising out of and in the course of the employment. The worker or dependant has no choice but to claim compensation. In situations where the third party on a claim is reported to be a worker, it must also be established that the activities of this "worker" were arising out of and in the course of his or her employment.

Where an action is barred under Section 10(1) in respect of a work injury, the same applies to any subsequent injury occurring in the course of treatment or rehabilitation which is accepted as a compensable consequence of that injury.

EFFECTIVE DATE: For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #111.10 of Volume II of this *Manual* regardless of the date of original work injury or the further injury.

#*111.11 Employer or Worker Partly at Fault*

If, in any action brought by a worker or dependant of a worker or by the Board, it is found that the injury, disablement, or death, as the case may be, was due partly to a breach of duty of care of one or more employers or workers under the Act, no damages, contributions, or indemnity are recoverable for the portion of the loss or damage caused by the negligence of such employer or worker; but the portion of the loss or damage caused by that negligence shall be determined although the employer or worker is not a party to the action. (1)

#111.20 Injury Not Caused by Worker or Employer

Section 10(2) provides that "Where the cause of the injury, disablement or death of a worker is such that an action lies against some person, other than an employer or worker within the scope of this Part, the worker or dependant may claim compensation or may bring an action. If the worker or dependant elects to claim compensation, he or she must do so within 3 months of the occurrence of the injury or any longer period that the board allows."

Section 79(1) of the *Motor Vehicle Act* gives a right of action to a person injured in a motor vehicle accident against the owner of the vehicle in question where it was being driven by a member of the owner's family living under the same roof or any other person driving with the owner's consent. Even though an action against the driver is barred under Section 10(1), the action against the owner may still lie, with the result that the claimant must make an election under Section 10(2). This could occur, for example, where the owner takes her or his vehicle to a garage for repair and the accident occurs while it is being test driven by a mechanic.

In determining whether there must be an election under Section 10(2), consideration is given to whether there is a right of action against the manufacturer, designer, etc. of a product which caused the injury. The action against such a person will be barred under Section 10(1) if she or he is an employer covered by the Act, but not if she or he is located outside the province.

#*111.21 Competence to Make Election*

Where the Board is satisfied that due to a physical or mental disability a worker is unable to exercise the right of election, and undue hardship will result, it may pay compensation until the worker is able to make an election. If the worker then elects not to claim compensation, no further compensation may be paid, but the compensation so paid is a first charge against any sum recovered. (2)

An application filed by a parent, guardian, or the official guardian for compensation for the infant child of a deceased worker is a valid election on behalf of that child. (3)

A worker under the age of 19 years can make a valid election. (4)

#*111.22 Form of Election*

Any signed notification from a worker or dependant outlining her or his decision is a valid election. A Form 6 Application for Compensation (5) could constitute an election. However, to ensure that the worker is fully aware of the implications of making the election, the Board also forwards an explanatory brochure entitled "Legal Actions and the Right to Choose". Enclosed with the brochure is the Board's Form 25W75, "Third Party Election Covering Non-Motor Vehicle Accidents", or a Form 25W78, "Election Covering Third Party Motor Vehicle Accidents".

#*111.23 Election Not to Claim Compensation*

If an injured worker decides to proceed with a law suit, no action is taken on the claim by the Board. The worker simply retains a lawyer to prosecute the case.

If, after trial, or after settlement out of court with the written approval of the Board, less is recovered and collected than the amount of the compensation to which the worker or dependant would be entitled under the Act, the worker or dependant is entitled to compensation to the extent of the amount of the difference. (6) Therefore, if a worker fails in the law suit or is only partially successful, the worker is able to claim the difference from the Board and thereby end up with at least as much as he or she would have received if compensation had been claimed from the Board initially. A question arises as to the meaning of the word "difference". For the purpose of Section 10(5), it will be the actual amount of the judgment or settlement in the claimant's action with no deduction being made for the costs of obtaining the judgment.

The submission of an application to the Board must have been made within the time limits laid down for applications for compensation in order that a subsequent request for the difference can be considered. (7)

#111.24 Election to Claim Compensation

If an injured worker or dependant elects to claim compensation from the Board rather than take their own action, the claim is processed in the usual way and they receive the usual compensation benefits from the Board. They cannot revoke the election after any payment has been made, except by immediate repayment of all monies paid out under the claim.

Section 10(6) provides in part that "If the worker or dependant applies to the board claiming compensation under this Part, neither the making of the application nor the payment of compensation under it restricts or impairs any right of action against the party liable, but as to every such claim the board is subrogated to the rights of the worker or dependant and may maintain an action in the name of the worker or dependant or in the name of the board; . . ."

A person cannot therefore claim both compensation benefits and pursue a court action. If the person claims compensation, the Board is subrogated to the action. If the person chooses to sue, no compensation benefits are received. There is no right to receive compensation on a temporary basis while pursuing a court action on the understanding that the benefits will be repaid following that action. If, pursuant to #111.21, a claimant receives compensation prior to making an election, the compensation is terminated immediately that an election is made not to claim compensation.

Pre-conditions also exist in the case of an emergency service worker's ability to receive compensation. No compensation is payable to the Emergency Services Worker or legal representative or dependant, as the case may be, unless he or she:

(a) assigns and subrogates or assign and subrogate to the Workers' Compensation Board his or her rights against any person against whom any action may lie with respect to the said accident; and

(b) releases or release Canada and B.C. and all its or their officers, servants, agents and employees of Her Majesty's Armed Forces from any and all liability arising out of or connected with the said accident.

#111.25 Pursuing of Subrogated Actions by the Board

Where the Board is subrogated to an action following a claimant's election to claim compensation, it has exclusive jurisdiction to determine whether it shall maintain or compromise the right of action, and the decision of the Board is final and conclusive. (8) The Legal Services Division of the Board determines whether there is a cause of action against a third party, and whether it is one that is worth pursuing.

Where the Legal Services Division decides to pursue the claim, conduct of the action is carried within the Legal Services Division, except where an outside counsel is more practicable. Where an outside counsel is retained, the Legal Services Division will carry out the selection and provide written instruction.

The Legal Services Division will not select a lawyer proposed by the claimant. It will be made clear in the written instructions that the outside counsel is acting on behalf of the Board, and that the full recovery is to be paid to the Board, subject to recognition of the lawyer's lien for fees and disbursements. The Board will account to the claimant for any excess.

If the Legal Services Division concludes that there is no claim worth pursuing, but the claimant or the claimant's lawyer disagrees, the claimant may be permitted to select a lawyer to conduct an action and the lawyer will be advised:

(a) that the action is one the Legal Services Division does not consider worth pursuing;

(b) that if the lawyer is of a different opinion, he or she may be authorized to pursue an action on behalf of the Board and the claimant on the terms that if there is a successful recovery, the full recovery is to be paid to the Board, subject to recognition of a lien for fees and disbursements; Further, that if the action is not successful, the Board will not be responsible for fees and disbursements;

(c) of the amount of the Board's claim or, if that is not possible, of an indication that the amount of the Board's claim remains to be determined.

This procedure will not be followed where it is felt that the risk of liability for costs clearly exceeds any likelihood of recovery.

Where action is taken by the Board, a claim is advanced which includes not only the disbursements paid out on the claim by the Board, but all items or damages which the claimant could have recovered if action had been taken on his or her own. It is expressly provided in Section 10(10) that "In an action brought under this section, an award for damages is to include

(a) health care provided under this Part; and

(b) wages and salary paid by an employer during the period of disability for which regard has been had by the board, or would have been had if the worker had elected to claim compensation, in fixing the amount of a periodical payment of compensation."

The mere fact that in a court action the Board has claimed damages for a particular item does not mean that that item has been accepted as part of the claimant's compensation claim.

Costs may, notwithstanding that a salaried employee of the Board acts as its solicitor or counsel, be awarded to and collected by the Board in any action taken by the Board. (9)

Section 10(6) provides in part that ". . . if more is recovered and collected than the amount of the compensation to which the worker or dependant would be entitled under this Part, the amount of the excess, less costs and administration charges, must be paid to the worker or dependant." Thus, if the action is successful, the Board's disbursements, i.e. the amounts it has paid for wage-loss compensation and health care benefits together with administration costs, are deducted from the amount recovered and the excess is then paid to the claimant or dependant. If the action is not successful, all costs are paid by the Board.

When the excess has been paid to the claimant, and the claim is reopened at a future date, the excess paid will be taken into consideration before any further payment of compensation is made on the claim.

There are particular rules applicable when an action that is pursued arises out of an accident suffered by an Emergency Services Worker. The Provincial Emergency Program agreement states, "Where compensation or health care (hereinafter "compensation") is paid or provided and the Workers' Compensation Board has, pursuant to subrogation from the person claiming compensation as an Emergency Services Worker or from his legal representative or his dependents, (sic) as the case may be, to whom compensation is paid, recovered an amount from any person with respect to the said accident, the Workers' Compensation Board shall reimburse Canada and B.C. in an amount that bears the same relation to the amount so recovered, less reasonable costs and reasonable administration expenses, as the amount paid by Canada and B.C. bears to the amount of the compensation determined."

#111.26 Failure to Recover Damages

Where the Board is unsuccessful either in total or in part in recovering damages from a third party and the third party has an entitlement to benefits from the Board, the recovery will be made from such benefits. If there is no existing entitlement to benefits, a record of the indebtedness will be made by the Board and should any future entitlement to benefits accrue, a recovery will be made from that entitlement. As a general guideline, this recovery will follow the limits set out in the *Court Order Enforcement Act*. Such limitations would not apply in the case of a functional pension where the indebtedness may be recovered from the pension capital reserve.

#111.30 Meaning of "Worker" and "Employer" under Section 10

In the provisions discussed in #111.10-24, "worker" and "employer" have the meaning given to them in Chapter 2.

For the purpose of Section 10, "worker" includes an employer entitled to personal optional protection. (10) However, this does not affect status as an employer under this section in regard to other workers.

The meanings of "employer", "worker", and "employment" for the purpose of Section 10 in claims concerning commercial fishers are discussed in Fishing Industry Regulation 14 (found in Workers' Compensation Reporter Decision 223).

#111.50 Federal Government Employees

The provisions discussed in #111.00-40 above have no application to employees entitled under the *Government Employees Compensation Act*.

Rules similar to those set out in #111.00-40 are set out in Section 9 of that Act. In general, the claimant is precluded from suing the government in respect of an employment accident, but must claim compensation. Where the circumstances of the accident give rise to a right of action against someone other than the government, the claimant must elect either to sue that other person or claim compensation. If the claimant does the latter, the government is subrogated to the right of action. These subrogated actions are administered by the Federal Government directly. The Board is not concerned in them.

#112.00 INJURIES OCCURRING OUTSIDE THE PROVINCE

Section 5(1) provides in part that compensation is payable where ". . . personal injury or death arising out of and in the course of the employment is caused to a worker . . ." It places no limitation on the place of injury. On the face of it, it might be held to apply to all employment injuries, whether they occur inside or outside the province. The Board has, however, concluded that the section could not be intended to have such a broad effect. The *Workers Compensation Act* only applies to injuries occurring outside the province where its provisions expressly provide for this, or do so by necessary implication. There are two main situations that have to be considered which are discussed in #112.10 and #112.20.

The payment of health care benefits for costs incurred outside the province is discussed in #73.50.

#112.10 Claimant is Working Elsewhere than in the Province

Section 8(1) provides that "Where the injury of a worker occurs while the worker is working elsewhere than in the Province which would entitle the worker or the worker's dependants to compensation under this Part if it occurred in the Province, the board must pay compensation under this Part if

(a) a place of business of the employer is situate in the Province;
(b) the residence and usual place of employment of the worker are in the Province;
(c) the employment is such that the worker is required to work both in and out of the Province; and
(d) the employment of the worker out of the Province has immediately followed the worker's employment by the same employer within the Province and has lasted less than 6 months,

but not otherwise."

Section 8 does not apply to commercial fishers.

#112.11 Meaning of Working in Section 8

Section 8(1) only applies "Where the injury of a worker occurs while the worker is working elsewhere than in the Province . . ."

In a Board decision, a claimant who lived in the province of Alberta was employed by an employer located in the province. Each day, he travelled into the province to come to work on a bus provided by his employer. He was injured in an accident in which this bus was involved while still on the Alberta side of the border. It was decided that he was at the time of his injury working in the province rather than the province of Alberta with the result that Section 8 had no application.

The Board has on prior occasions, when discussing the meaning of the phrase "arising out of and in the course of the employment" in Section 5(1), pointed out that compensation coverage was not limited to "work" in the sense of productive activities. The Act covers a much broader range of productive and non-productive activities which comprises the "employment". (11) This distinction between "employment" and "work" activities is also material when interpreting Section 8(1). The place where a person performs the productive, as opposed to the non-productive, activities of the person's employment is generally the best indicator of where the person works. If someone were to ask the claimant in the example above where he worked, he would no doubt have stated that he worked at the person's employer's plant in British Columbia, because that is where his main job function was carried out. The answer would be no different just because part of his journey to work took place in Alberta or, in another case, because the claimant was required to perform some incidental job function

outside the province. Under this interpretation, the concern is not with the particular activity being carried on at the moment of injury, but the place where the claimant performs the major job functions with which that activity is associated.

In other cases, the interpretation of Section 8(1) adopted above may raise difficult questions as to whether a claimant's main job function at the time in question is in the province or elsewhere. There will be less obvious cases where the claimant is performing significant amounts of productive work activity both inside and outside the province. Since Section 8(1) clearly contemplates that there will be periods of work outside the province where the claimant does have to meet the criteria it lays down, it will be necessary to draw a line in these cases between productive activities which are merely incidental to "working" in this province and productive activities which are sufficient to constitute "working elsewhere".

In making this judgment, regard will primarily have to be taken of the length of time for which the productive activity is performed outside the province. If the period of absence is less than one day, it will probably, in most cases, be safe to say that the activity is simply incidental to the work performed in the province. On the other hand, where the length of time is greater than a week, it would probably have to be concluded that the claimant was "working elsewhere than in the Province". Periods of between a day and a week would probably have to be dealt with on the individual merits, having regard, in particular, to the nature and circumstances of the claimant's employment.

Another factor that must be considered is the degree of regularity with which a claimant does productive work outside the province. The more regularly this is done, the shorter is the period of productive work outside the province which would be sufficient for the claimant to be considered as "working elsewhere". For example, even though the period out of the province is less than a day, the claimant might be held to be working outside the province if this was done routinely.

#112.12 *Residence and Usual Place of Employment*

Section 8 of the Act was intended to provide a convenient and efficient form of coverage for industries which, although normally based in this province, may occasionally require assignment of workers to locations outside the province. Taken as a whole, the section contemplates the coverage of workers who live in British Columbia, who spend the greater part of their time performing a particular kind of work in British Columbia, but who are assigned for limited periods of time by the same employer and for the same work to other jurisdictions. It was not intended to cover situations where, although there is a place of business of the employer in the province, virtually all of that company's work takes place outside of the province and is performed, for the most part, by employees who neither live nor work in British Columbia.

While it is impossible to lay down specific rules and guidelines for the words "residence and usual place of employment", they must be defined in relation to the broader view of the section as outlined above.

For British Columbia to qualify as the residence and usual place of employment of a worker under Section 8, the evidence must reveal more than short-term transient accommodation and must show that the work performed in British Columbia is more consistent and long-term than that performed in the other jurisdiction(s) in question.

In a Board decision, the claimant's employer had its head office and base of operations in this province. The claimant underwent a two-week training period at the head office, but all his work was outside of the province. The claimant lived primarily in Ontario and had rented no accommodation in this province during his two-week stay. He did, however, have a bank account here. He was injured in Washington State. His claim was denied because his "residence" and "usual place of employment" were not in British Columbia.

#112.13 *Employment of the Worker out of the Province has Immediately Followed Employment by the same Employer within the Province and has Lasted less than Six Months*

Upon first reading, Section 8(1)(d) appears to require that the injury must occur in the jurisdiction to which the worker has gone directly from British Columbia. However, it does no more than recognize that there exists two classes of employment, those "in-province" and those "out-of-province". It requires that employment out-of-province must last less than six months and must immediately follow employment by the same employer within the province; but it makes no reference to where, outside the province, the employment may take the worker.

As long as the other criteria of the section are met, no objection to a claim should be taken on the basis that a worker went from British Columbia to another jurisdiction and then on to a second or third jurisdiction before the injury occurred. As long as the injury was within the six months and employment was with the same employer, the provisions of the subsection are met.

The word "immediately" would, by normal reference to dictionary definitions, refer to considerations of time. However, because of the nature of the entire section, it is possible to view the term in relation to employment as well. For example, a worker may be employed by a particular employer in British Columbia, leave and go to work for another employer for a short period of time, and then return to the original employer but hiring on in another jurisdiction. In that case, the worker will not have been employed by the same employer within the province immediately prior to going to the other jurisdiction and would be barred from a

claim for compensation by the subsection. On the other hand, if the worker were to work for an employer within the province and, due to the absence of any further employment prospects, be laid off and then hire on again within the province with the same employer and be assigned immediately to work in another jurisdiction, it could reasonably be concluded that by having worked for the same employer and no one else, and by having been hired in British Columbia, albeit to work only in another jurisdiction, the requirements of the subsection had been met.

#112.20 Claimant is Working in the Province

The decision discussed in #112.11 provides an example of when a claimant might be working in the province but yet injured outside the province while in the course of his employment. Though the provisions of Section 8(1) were not applicable to that claim, it was decided that the claim could be accepted under Section 5(1).

Where there is an out-of-province injury, the first question that must be asked is where, at the time in question, the claimant was performing his main job functions. The concern will not be with the particular activity being engaged in at the moment of the injury. If the claimant's main job at the time is being performed outside of the province, the claim must satisfy the requirements of Section 8(1), including the requirement that he be a resident of the province. If those functions are being performed in the province, he only has to meet the requirements of Section 5(1) and Section 8(1) has no application. Since the main job function of the claimant in this decision was in the province at the time of his injury and his injury did arise out of and in the course of his employment, his claim was an acceptable one even though he did not reside in the province.

#112.30 Workers Also Entitled to Compensation in Place of Injury

Section 9(1) provides in part that "Where by the law of the country or place in which the injury or occupational disease occurs the worker or the worker's dependants are entitled to compensation in respect of it, they must elect whether they will claim compensation under the law of that country or place or under this Part, and to give notice of the election. If the election is not made and notice given, it must be presumed that they have elected not to claim compensation under this Part; . . ."

The right of election is subject to the terms of any interjurisdictional agreement. (12)

Notice of the election must be given to the Board within three months after the occurrence of the injury or disablement from occupational disease, or, if it results in death, within three months after the death, or within any longer period that either before or after the expiration of the three months the Board allows. (13)

In addition to the election form noted above, a Form 6 Application for Compensation is also required. A claim for compensation, made to the Workers' Compensation Board of the place where the injury or exposure to the causes of an occupational disease occurs, constitutes an election to claim under the law of that place.

#112.31 Occupational Disease

It may happen that the occupational disease suffered by a worker is due to exposure in the course of employment both inside and outside the province. If the exposure within the province is not significant, the Board will not accept responsibility for the claim, subject to the terms of any interjurisdictional agreement. If the exposure within the province is significant, the Board will accept responsibility of the whole of the worker's problem. There will, in general, be no apportionment of liability. The worker may, however, be required to elect to claim in this province under Section 9(1). Where the Board is accepting full responsibility for the condition, the worker cannot claim in both this province and another province or territory.

An exception exists for hearing-loss claims. As discussed in #31.20, liability will be apportioned where more than 5% but under 90% of the claimant's exposure was outside the province.

#112.40 Federal Government Employees

Federal Government employees must claim compensation in the province where they are usually employed regardless of the place of injury. (14)

NOTES

(1) S.10(7)
(2) S.10(3)
(3) S.10(4)
(4) S.12; #49.00
(5) #93.20
(6) S.10(5)
(7) #93.20
(8) S.10(6)
(9) S.10(11)
(10) S.10(9); S.3(3)
(11) See #14.00
(12) See #113.30
(13) S.9(2)
(14) #24.00

CHAPTER 17

CHARGING OF CLAIM COSTS

#113.00 INTRODUCTION

The general practice followed by the Board is that the cost of any compensation paid out on a claim is charged to the class or subclass of employers of which the claimant's employer is a member. These costs are not paid directly by the employer. Rather, the employer will, through the assessment rate, pay a proportion of the total costs incurred on all claims made by employees of all the employers in the subclass. The proportion paid is the proportion which the employer's payroll bears to the total payrolls of all employers in the subclass. This may be adjusted through a system of experience rated assessments.

In certain cases, the class or subclass consists of one major employer so that the employer does directly pay the costs of the claim. Examples are the Canadian National Railway, Air Canada, Canadian Pacific, and the Provincial Government. These are termed deposit classes.

There are certain provisions in the *Workers Compensation Act* which result in exceptions to the above rule. An individual employer or the class or subclass may be relieved of the costs of compensation incurred on a particular claim. Alternatively, an individual employer may be charged with costs additional to the employer's ordinary liability as a member of a class or subclass. None of these special relieving or charging provisions apply to claims by Federal Government employees.

The amount of costs attributed to an employer are disclosed to an employer in the cost statements which are sent regularly. These list the claims concerned and the amount of costs incurred on each.

#113.10 Investigation Costs

Costs may be incurred prior to making a decision on a claim in investigating the validity of the claim or in paying benefits pursuant to an interim adjudication. Where the decision is ultimately in the worker's favour, these costs are charged to the employer's class in the normal way. Where the decision is unfavourable to the worker, these costs will not be charged to the employer's class, but will be spread across all classes. They are treated in effect as an administration cost.

The same rule also applies where:

1. A claim is accepted in error or benefits paid in error;

2. A decision is reversed by the Review Division, Workers' Compensation Appeal Tribunal or Medical Review Panel;

3. There is a reconsideration by a Board officer, Manager or Director.

The employer's class is relieved where the original decision was favourable to the worker and benefits were paid pursuant to it. Conversely, the class will be charged with costs already incurred where the previous decision was unfavourable to the worker.

For another situation where the class of employers is relieved of costs as investigation costs, see the policy on suffering an occupational disease at policy item #26.10.

EFFECTIVE DATE: March 3, 2003 (as to reference to the Review Division, the Workers' Compensation Appeal Tribunal and to reconsideration by a Manager or Director)

APPLICATION: Not applicable.

#113.20 Occupational Diseases

The long period of exposure required for the development of some occupational diseases raises special problems in connection with the charging of claim costs. The position is the same as for injuries when the exposure has been with one employer only, but there are commonly situations where the relevant exposure has occurred during employments with two or more employers. The general rules followed in these cases are as follows:

1. All wage-loss and health care benefits are charged to the class of the employer at the time the claim was submitted for the first 13 weeks.

2. An assessment of the claimant's work exposure history is then made and an apportionment of the costs incurred beyond 13 weeks, including the amount of any pension reserve, is carried out. The class of the employer at the time the claim is submitted will be charged with the portion of costs incurred after the 13 weeks, which is attributable to the claimant's employment with the employer, provided that that portion exceeds 20% of the total amount. The balance will not be charged to any particular class but will be spread across all classes of industry.

3. Where any portion attributable to any employer at the time the claim is submitted is less than 20%, the costs incurred following 13 weeks are not charged to any employer's class, but will be spread across all classes of industry. To ensure procedural fairness in the event of a request for review or an appeal in such situations, decision letters and review and appeal information is sent to the employers' association that best represents the appropriate class and subclass of industry.

4. The apportionment is made by comparing the number of years of exposure with the employer at the time the claim is submitted with the claimant's total exposure. No account is taken of varying degrees of exposure which may have occurred at different times.

EFFECTIVE DATE: March 3, 2003 (as to references to review)
APPLICATION: Not applicable.

#113.21 Silicosis and Pneumoconiosis

When, in the case of silicosis or pneumoconiosis claims, there is exposure to silica or other dust in more than one subclass of industry within the Province, costs are normally apportioned on the basis of employment records confirming the exposure. Occasionally, it is difficult to be precise about exact periods of exposure because absolute confirmation of employment is not always available many years after the fact. This is because employers may no longer be in business or the worker is unable to provide a complete resume of employment. Under the circumstances, there may be a few cases where it is unfair to simply use employment records for the charging of costs, particularly if there is other substantive evidence available to support exposure to silica dust in a certain class or classes of industry. The Board has therefore decided to give the Claims Adjudicator responsible for handling silicosis claims discretion in the apportionment of costs where it appears that the sole use of employment records will produce an inequitable result.

The guidelines set out below are followed:

1. Cost for silicosis of pneumoconiosis claims will normally be apportioned on the basis of confirmed periods of employment in industries where there is exposure to silica or other dust.

2. Where confirmed employment records are unavailable, but there is other substantive evidence to support periods of exposure to silica or other dust, the Claims Adjudicator responsible for silicosis and pneumoconiosis claims has discretion to apportion costs on the basis of the best evidence available.

3. Where a worker is entitled to compensation for silicosis or pneumoconiosis under the terms of Section 6 of the *Workers Compensation Act*, the costs will be charged to the appropriate class or classes of industry within the province of British Columbia as provided by the Act.

#113.22 Hearing-Loss Claims

Section 7(7) of the *Workers Compensation Act* provides that "Where a worker suffers loss of hearing caused by exposure to causes of hearing loss in 2 or more classes or subclasses of industry in the Province, the board may apportion the cost of compensation among the funds provided by those classes or subclasses on the basis of the duration or severity of the exposure in each."

The procedure followed to implement this provision is set out below.

1. An assessment is made of the claimant's work exposure history and an apportionment made as between the various employers concerned of the cost of compensation paid out. The apportionment is made by allocating to each period of employment a factor varying in accordance with the loudness of the noise experienced and multiplying this by the number of years exposed in each employment. The resulting figures for each employment are totalled and the percentage attributable to each is calculated by reference to this total.

2. The costs of a claim are attributed to individual employers in accordance with their percentage where those percentages are 20% or greater. Where the percentages of any employers are less than 20%, the equivalent percentages of the costs of the claim are not attributed to any particular employer, but are still charged to the appropriate class of industry.

3. Where the total exposure in this province is 5% or less, the claim is disallowed. Where the total exposure in this province is 90% or greater, the Board accepts responsibility for the whole hearing loss.

4. Where there is only one employer, but (because of non-occupational or out-of-province exposure) responsibility is less than 20%, the full costs of the claim are nevertheless attributed to that employer. (1)

#113.30 Interjurisdictional Agreements

Section 8.1(1) provides as follows:

"The board may enter into an agreement or make an arrangement with Canada, a province or the appropriate authority of Canada or a province to provide for

(a) compensation, rehabilitation and health care to workers in accordance with the standards established under this Act or corresponding legislation in other jurisdictions,

(b) administrative co-operation and assistance between jurisdictions in all matters under this Act and corresponding legislation in other jurisdictions, or

(c) avoidance of duplication of assessments on workers' earnings."

The agreement entered into contains provisions to deal with situations where an injury, or exposure to the causes of an occupational disease occurs in another province or territory. In addition, it contains a system to permit the Board to help another Board's workers or dependants and a method of resolving disputes between Boards.

An employer who carries on business in this province may be required to register with this Board as an employer even though carrying on business and is registered as an employer with the Board in another province or territory. (2)

Where an employee of such an employer suffers from an injury or occupational disease and is eligible to claim compensation in this and another province or territory, the employer's class will be charged with the costs of the claim subject to adjustment resulting from any reimbursements received or made under the terms of the Interjurisdictional Agreement.

#113.40 *Blind Workmen's Compensation Act*

The *Blind Workmen's Compensation Act* was repealed June 26, 1975. Its provisions, however, remain applicable to injuries to blind workers where the injuries occurred prior to June 26, 1975.

Under these provisions, the consolidated revenue fund of the Province pays for all but the first $50 of the cost of an industrial injury to a blind worker.

#114.00 PROVISIONS RELIEVING CLASS OF COSTS OF CLAIM

#114.10 Transfer of Costs from One Class to Another

Section 10(8) provides as follows:

> "The provisions of this Part are in lieu of any right of action that the employer of the injured or deceased worker is or may, in respect of the personal injury or death of the worker, be entitled to maintain against another employer within the scope of this Part, or an independent operator to whom this Part applies by direction under section 2(2)(a); but where the board considers that
>
> (a) a substantial amount of compensation has been awarded as a result of the injury or death of the worker; and
>
> (b) the injury or death was caused or substantially contributed to by a serious breach of duty of care of an employer or an independent operator to whom this Part applies by direction under section 2(2)(a) in another class or subclass,
>
> the board may order that the compensation be charged, in whole or in part, to the other class or subclass; but the provisions of this subsection do not affect any right which an employer may have against another employer, or an independent operator to whom this Part applies by direction under section 2(2)(a), arising out of their indemnity agreement or contract. "

This provision permits the Board to transfer the costs of a claim from the class of the claimant's employer to the class of another employer in certain circumstances. The requirements of such a transfer are discussed below.

#114.11 The Amount of Compensation Awarded Must Be Substantial

The Board has interpreted the word “substantial” as referring to a specific dollar amount. The amounts in question are set out below:

January 1, 1999 – December 31, 1999	$34,499.05
January 1, 2000 – December 31, 2000	35,290.32
January 1, 2001 – December 31, 2001	36,271.48
January 1, 2002 – December 31, 2002	36,967.79

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

After January 1, 1993, the dollar amount 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).

#114.12 Serious Breach of Duty of Care of Another Employer Must Have Caused or Substantially Contributed to Injury

"Duty of care" has the same meaning as it does in the law of tort. It is therefore relevant to consider what conclusions a court of common law would come to if a claim for damages for personal injury were brought by the claimant against the other employer. The basic question considered is whether there was a failure to take reasonable care. The mere fact that the employer may have violated the Occupational Safety and Health Regulations is not sufficient since they often impose strict liability.

The doctrine of vicarious liability has no application to Section 10(8), and a transfer of costs is only available where the breach of duty of care consisted of acts or omissions by management personnel who can be identified as the employer, and not to cases where the breach of duty consists only of the act or omissions of other workers.

If there has been a breach of duty of care by the employer, the next question to be considered is whether it was a "serious" one. The word "serious" refers to the culpability of the employer's behaviour rather than the consequences of that behaviour. Regard will be had to the probability of injury resulting from the breach and the predictable gravity of the likely consequences of such an injury.

The fact that the claimant was negligent does not necessarily mean that the employer's breach of duty did not cause or substantially contribute to the injury. Lapses of attention are a normal part of ordinary human behaviour that should be foreseen and guarded against.

#114.13 Discretion of the Board

The Board has a discretion where the requirements set out in #114.10-12 are satisfied to transfer all or part of the cost of a claim. In exercising this discretion, the Board takes no account of any contributory negligence by the claimant.

#114.20 Depletion or Extinction of Industries or Classes

Section 39(1)(b) requires the Board to "provide a reserve in aid of industries or classes which may become depleted or extinguished; . . ."

Employers may apply to have the costs of a claim transferred from their class to that fund. This provision is very rarely used.

#114.30 Disasters or Other Circumstances which Unfairly Burden a Class

Section 39(1)(d) requires the Board to provide a reserve to meet the loss arising from a disaster or other circumstances which the Board considers would unfairly burden the employers in a class.

Costs will not be charged to the fund created by Section 39(1)(d) because there is an unfair burden on an individual employer. The unfair burden must be on a class or subclass of employers.

Each deposit account employer forms a class by itself. This does not automatically mean that a burden on the individual is a burden on the class. The relief available to deposit accounts under Section 39(1)(d) is limited to the same sorts of situations as for other employers.

#114.40 Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability

Section 39(1)(e) requires the Board to "provide and maintain a reserve for payment of that portion of the disability enhanced by reason of a pre-existing disease, condition or disability."

The section is applied most frequently in cases where a pension award has been made. There are, however, claims where temporary total or temporary partial disability can be said to have been protracted by reason of a pre-existing disease, condition or disability. In such cases, no consideration will be given to the application of Section 39(1)(e) until the claimant has been temporarily disabled for a minimum period of 13 weeks following the injury. All of the costs of a claim cannot be charged under Section 39(1)(e).

Since the section specifically refers to the enhancement of "disability", it has no application in fatal cases or in cases where only health care benefits are payable.

Two questions are considered when evaluating the application of Section 39(1)(e):

1. Was there a pre-existing disease, condition or disability and, if so, to what extent?

2. How severe was the incident initiating the claim in question?

Obviously, if a worker suffers an injury and there is no evidence of any pre-existing disease, condition or disability, the subsection is inapplicable. Similarly, where there is confirmation of a pre-existing disease, condition or disability of a minor degree, but the incident which precipitated the instant claim was of a severe nature, the section may be considered but will normally not be applicable. However, the section will clearly be applicable to those situations where a worker suffered a relatively minor injury at the time the instant claim was initiated, but there is evidence that the recovery period was prolonged, or a permanent disability was enhanced, by reason of a pre-existing disease, condition or disability. The fact that a disability has been prolonged or enhanced by other factors than a pre-existing condition is not a ground for relief under Section 39(1)(e).

How much disability stems from the injury and how much from the enhancement of the disease, condition or disability and, therefore, to what extent costs should be charged under Section 39(1)(e) can never be more than an estimate and will always be difficult to determine. In cases of continuing wage-loss and health care benefits, it will be appropriate for the Claims Adjudicator to determine that all of the costs of these benefits after a particular point in time should be charged under Section 39(1)(e). In some instances, it may be appropriate for the Claims Adjudicator to charge such costs on a percentage, rather than a time basis. In respect of permanent partial or permanent total disabilities, it will be necessary for the Disability Awards Officer or Adjudicator in Disability Awards, using her or his own best judgment and having reference to the advice of the Disability Awards Medical Advisor, to establish a percentage applicable to the pre-existing condition and to charge the relevant costs accordingly.

APPLICATION: For all initial section 39(1)(e) cost relief decisions made on or after August 1, 2007, refer to policy item #114.40 of Volume II of this *Manual*, regardless of the date of the compensable injury.

#114.41 Relationship Between Sections 5(5) and 39(1)(e)

It is important to distinguish between the provisions of Section 5(5) discussed in #44.00 and Section 39(1)(e). Section 5(5) deals with the situation where a disability resulting from a work injury is superimposed on a pre-existing disability in the same part of the body and increases that disability. (As outlined in #44.31, Section 5(5) can also apply if a pension is being assessed on a loss of earnings basis under Section 23(3) of the *Workers Compensation Act* and the disability is deemed to be partly the result of a disability in another part of the body.) It may result in a reduction in the amount of compensation paid to the claimant. Section 39(1)(e) is concerned only with the class to which the costs of the claim are to be charged and cannot affect the entitlement of the claimant. It can apply in cases where Section 5(5) does not apply and the whole of the claimant's disability results from the injury or, if Section 5(5) does apply, to the portion of

disability for which the Board is responsible. It provides relief for the class of the claimant's employer when the disability or portion of disability accepted under the claim is worse because of a pre-existing disease, condition or disability than it otherwise would be. That condition might well be in a different part of the claimant's body.

APPLICATION: For all initial section 39(1)(e) cost relief decisions made on or after August 1, 2007, refer to policy item #114.41 of Volume II of this *Manual*, regardless of the date of the compensable injury.

#114.42 Application of Section 39(1)(e) to Occupational Diseases

Section 39(1)(e) will not be applied to occupational disease claims simply because the disease results from exposure in several different employments. That situation is dealt with in #113.20. However, there may be cases where the disability caused by an occupational disease was enhanced by a pre-existing condition. Section 39(1)(e) can be applied in such cases if the criteria outlined in #114.40 are met.

#114.43 Procedure Governing Applications under Section 39(1)(e)

The Board has the responsibility to initiate consideration with or without a specific request or application by an employer, and to decide upon the applicability of the subsection on a claim. If a decision is made to apply this subsection, the employer will be notified. If relief has been requested, the employer will be advised if it has been denied. If there is a disagreement with such a decision, the employer may request a review by the Review Division.

EFFECTIVE DATE: March 3, 2003 (as to reference to review)
APPLICATION: For all initial section 39(1)(e) cost relief decisions made on or after August 1, 2007, refer to policy item #114.40 of Volume II of this *Manual*, regardless of the date of the compensable injury.

#114.50 Sections 39(1)(d), 39(1)(e) and Federal Government Claims

The Federal Government does not contribute to the Accident Fund, therefore no relief of costs can be made where the Federal Government is recorded as the injury employer, i.e. Class 19 Claims.

APPLICATION: For all initial section 39(1)(e) cost relief decisions made on or after August 1, 2007, refer to policy item #114.40 of Volume II of this *Manual*, regardless of the date of the compensable injury.

#115.00 PROVISIONS CHARGING INDIVIDUAL EMPLOYERS

One provision of this nature has been discussed in #94.15. Section 54(8) permits the Board to charge an employer with the costs of a claim where late in submitting a report of injury to the Board.

Other provisions of this nature are discussed below.

#115.10 Failure to Register as an Employer at the Time of Injury

Where an employer is an employer to which the Act extends compulsory coverage, failure to register with the Board as an employer will not prejudice any claim by the employees unless the provisions set out in Workers' Compensation Reporter 335 and 20:30:30 of the Assessment Policy Manual apply. However, the employer may be faced with paying the costs of the claim under Section 47(2) which provides as follows:

> "An employer who refuses or neglects to make or transmit a payroll return or other statement required to be furnished by the employer under section 38(1), or who refuses or neglects to pay an assessment, or the provisional amount of an assessment, or an instalment or part of it, must, in addition to any penalty or other liability to which the employer may be subject, pay the board the full amount or capitalized value, as determined by the board, of the compensation payable in respect of any injury or occupational disease to a worker in the employer's employ which happens during the period of that default, and the payment of the amount may be enforced in the same manner as the payment of an assessment may be enforced."

Section 38(1) provides that "Every employer must

(a) keep at all times at some place in the Province, the location of which the employer has given notice to the board, complete and accurate particulars of the employer's payrolls;
(b) cause to be furnished to the board
    (i) when the employer becomes an employer within the scope of this Part; and,
    (ii) at other times as required by a regulation of the board of general application or an order of the board limited to a specific employer, an estimate of the probable amount of the payroll of each of the employer's industries within the scope of this Part, together with any further information required by the board; and
(c) furnish certified copies of reports of the employer's payrolls, at or after the close of each calendar year and at the other times and in the manner required by the board."

The Board may, under Section 47(3), if satisfied that the default was excusable, relieve an employer in whole or in part from liability under Section 47(2).

The Board has decided that Section 47(2) applies to claims for fatalities.

The charge made under Section 47(2) is in addition to any ordinary assessments which the employer may be liable to pay for the period prior to the occurrence of the injury.

Item #113.30 dealt with the rules followed in charging the costs of claims where an employer is carrying on business in two or more provinces and is required to register in both. Where such an employer is not registered in this province at the time of an injury, there may be personal liability for the costs of the claim under Section 47(2) in any situation where, under the provisions of the Interjurisdictional Agreement or otherwise, the employer's class would ordinarily be charged.

#115.11 Procedure for Applying Section 47(2)

Following the acceptance of a claim, the Board officer will write to the employer and advise of the potential for liability under section 47(2). The employer will be invited to make comments as to why he or she should not be charged with the costs of the claim. A decision on the employer's liability, and whether or not to provide relief from any liability, will then be made by a committee comprised of the Board's General Counsel or delegate and the Director or Manager, Assessment Policy, of the Assessment Department. The employer may request a review by the Review Division of the decision.

The committee, when reviewing a claim for the purpose of section 47(2), will not consider arguments made by the employer which question the validity of the Board officer's decision to accept the claim. If the employer wishes to challenge that decision, he or she must exercise the right to request a review by the Review Division with respect to the acceptance of the claim.

EFFECTIVE DATE: March 3, 2003 (as to reference to review)
APPLICATION: Not applicable.

#115.20 Significance of Employers Conduct in Producing Injury

Generally speaking, whether or not an employer was at fault is not a material factor when determining how the costs of a claim are to be charged. The rules set out in policy item #113.00 apply both when the employer's negligence or misconduct caused an injury and when the injury was due to circumstances beyond the employer's control. However, an exception is provided by section 73(2), which states as follows:

> "Where an injury, death or disablement from occupational disease in respect of which compensation is payable occurs to a worker, and the

board considers that this was due substantially to the gross negligence of an employer or to the failure of an employer to adopt reasonable means for the prevention of injuries or occupational diseases or to comply with the orders or directions of the board, or with the regulations made under this Part, the board may levy and collect from that employer as a contribution to the accident fund the amount of the compensation payable in respect of the injury, death or occupational disease, not exceeding in any case $11,160.08, and the payment of that sum may be enforced in the same manner as the payment of an assessment may be enforced."

The Board has a discretion whether to charge an employer with the costs of a claim under this provision, but once it has decided to exercise that discretion, it has no choice but to charge the whole of the costs of the claim up to the maximum amount. It has no authority to charge a lesser amount or to relieve the employer in part.

The maximum amount is subject to Consumer Price Index adjustments, the figure set out above being applicable in the period January 1 to June 30, 1975. The amounts applicable in other periods are set out below:

July 1, 1995	– December 31, 1995	$36,188.70
January 1, 1996	– June 30, 1996	36,297.21
July 1, 1996	– December 31, 1996	36,704.13
January 1, 1997	– June 30, 1997	36,948.28

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

The maximum in force at the date of the accident is the one that applies in any case.

As an alternative to the charge under section 73(2), penalty assessment may be levied under section 73(1). These are general provisions allowing the Board to penalize employers for infractions of Occupational Safety and Health or First Aid Regulations or for other unsafe practices which apply whether or not an injury has occurred. Levies made under any of these sections are additional to the employer's ordinary liability to pay assessments and are credited to the Board's general funds rather than to the employer's class or subclass.

EFFECTIVE DATE: March 3, 2003 (as to deletion of reference to process for levies and penalties)

APPLICATION: Not applicable.

#115.30 Experience Rating

Section 42 provides as follows.

> "The Board must establish subclassifications, differentials and proportions in the rates as between the different kinds of employment in the same class as may be considered just; and where the Board thinks a particular industry or plant is shown to be so circumstanced or conducted that the hazard or cost of compensation differs from the average of the class or subclass to which the industry or plant is assigned, the Board must confer or impose on that industry or plant a special rate, differential or assessment to correspond with the relative hazard or cost of compensation of that industry or plant, and for that purpose may also adopt a system of experience rating."

The Board has adopted an experience rating plan (ER) under this section. The plan compares the ratio between an employer's claim costs and assessable payroll with the ratio between the total claim costs and assessable payroll of the employer's class. Subject to maximums, merits are assigned for favourable ratios and demerits for unfavourable ratios. The merit or demerit takes the form of a percentage increase or decrease in the usual assessment rate. Details of ER can be found in the *Assessment Policy Manual* (Policy No. 30:50:41).

As a general rule, all acceptable claims coded to a particular employer are counted for experience rating purposes. It makes no difference whether the injury was or was not the employer's fault. There are, however, some types of claim costs which are excluded from consideration. These are:

1. Costs recovered by way of a third party action (see policy item #111.25).

2. Investigation and/or compensation costs paid out prior to the disallow of a claim or reversal of a decision by a Board officer, the Review Division, the Workers' Compensation Appeal Tribunal or Medical Review Panel (see policy item #113.10).

3. Costs transferred to the class of another employer under section 10(8) (see policy item #114.10).

4. Costs assigned to the funds created by section 39(1)(d) and (e) (see policy item #114.30 and policy item #114.40).

5. Occupational disease claims which on average require exposure for, or involve latency periods of, two or more years before manifesting into a disability. The diseases presently excluded on this ground are:

Non-traumatic hearing loss, excluding hearing loss resulting from other injuries

Silicosis

Asbestosis

Other diagnosed pneumoconioses, for example, anthracosis and siderosis

Pneumoconioses not specifically diagnosed

Heart disease

Cancer

Hand-arm vibration syndrome, vinyl chloride induced Raynaud's phenomenon, disablement from vibrations

6. Costs after 13 weeks where section 5(3) applies (see policy item #16.60).

7. Costs from accidents substantially due to personal illness, e.g. epilepsy (see policy item #15.30).

8. Injuries during a retraining program sponsored by the Vocational Rehabilitation Department (see policy item #88.43, policy item #88.54).

9. The situations covered by policy item #115.31 and policy item #115.32 below.

The decision whether a claim falls within one of the exclusions will usually be made by an officer in the Compensation Services Division. In the case of third party actions (Exclusion 1), a Board solicitor makes the decision.

EFFECTIVE DATE: March 3, 2003 (as to references to the Review Division and the Workers' Compensation Appeal Tribunal)
APPLICATION: Not applicable.

#115.31 Injuries or Aggravations Occurring in the Course of Treatment or Rehabilitation

Where there is an aggravation of an injury or a subsequent injury arising out of treatment for the primary injury, and the aggravation or subsequent injury is acceptable on the claim, compensation costs resulting from this secondary

problem will be charged in the usual way. Exclusion from the employer's experience rating will only occur where:

1. the original injury was one that would not have been expected to result in death or permanent disability, and

2. the aggravation or subsequent injury occurred beyond the operations of the employer, and if the worker required transportation to a hospital or other place of medical treatment, after the employer had fulfilled the obligations under section 21(3) (see policy item #82.40), and

3. the aggravation or subsequent injury resulted in permanent disability or death.

The application of relief is limited to the pension reserve established for a fatality or permanent disability.

Consideration is automatically given by the Board officer to excluding the costs from experience rating in these cases. No request from the employer is required. The employer will be advised of the decision in writing and of the relevant review and/or appeal rights.

EFFECTIVE DATE: March 3, 2003 (as to the deletion of references to the Review Division and the Appeal Division)
APPLICATION: Not applicable.

#115.32 Claims Involving a Permanent Disability Award and a Fatality

ER does not include the actual cost of the fatal claims experienced by an employer. Rather, it includes for each claim the average cost for all fatal claims in the year.

A worker in receipt of a permanent disability pension may die as a result of the injury or disease accepted under the claim. If pensions are payable to dependants, the cost otherwise included in ER may be reduced to the extent set out below:

1. Where the average cost of a fatal award is the same or less than that of the permanent disability award, the total cost of the fatal award is excluded.

2. Where the average cost of a fatal award is greater than that of the permanent disability award, a portion of the cost of the fatal award equal to the reserve charged to the employer for the permanent disability award is excluded.

NOTES

(1) See #31.20
(2) See 20:30:40 Assessment Policy Manual
~~(3) See #112.30~~ **Deleted**
~~(4) See #82.40~~ **Deleted**
~~(5) See #82.40~~ **Deleted**
~~(6) S.96(6) and 96(7)~~ **Deleted**

APPENDIX 1

INDEX OF RETIRED DECISIONS FROM VOLUMES 1 – 6 (DECISIONS NO. 1 – 423) OF THE *WORKERS' COMPENSATION REPORTER*

EXPLANATORY NOTE:

The Board of Directors Bylaw re: Policies of the Board of Directors lists the policy manuals and other documents that are policies for purposes of the *Workers Compensation Act*. Included in the list are Decisions No. 1 – 423 in volumes 1 – 6 of the *Workers' Compensation Reporter*. These Decisions consist, for the most part, of decisions made by the former commissioners on various matters between 1973 and 1991.

In order to reduce the number of sources of policies, a strategy has been approved for consolidating Decisions No. 1 – 423 into the various policy manuals, as appropriate, and "retiring" the Decisions over time.

"Retire" for this purpose means that, as of the "retirement date", the Decision is no longer current policy under the Board of Directors Bylaw.

"Retiring" does not affect a Decision's status as policy prior to the date it was "retired". A "retired" Decision therefore applies in decision-making on historical issues to the extent it was applicable prior to the "retirement date". "Retiring" also does not affect the disposition of any individual matters dealt with in a Decision.

This Index sets out the Decisions from volumes 1 - 6 that have been "retired" and the "retirement date". It will be updated as further Decisions are "retired" in the future.[1]

Please note that as of April 1, 2006, only two Decisions from Volumes 1 – 6 of the *Workers' Compensation Reporter* remain to be retired: Nos. 99 and 231. These Decisions will be addressed in the near future.

[1] Decisions that do not appear in the Index should not necessarily be considered current policy. Decisions or parts of Decisions may have been replaced, either expressly or impliedly, by subsequent policies in the policy manuals or other policy documents. Under the Board of Directors Bylaw, where there is a conflict between policy in Decisions No. 1 - 423 and policy in a policy manual listed in the Bylaw, the policy in the manual is paramount. In the event of any other conflict between policies, the most recently approved policy is paramount.

DECISION NO.	TITLE	RETIREMENT DATE
01	Publication of Decisions	May 1, 2000
02	An Injured Person	February 24, 2004
03	A Claim For Industrial Disease	February 24, 2004
04	The Replacement of Eyeglasses	October 21, 2003
05	Partial Commutation of a Pension	June 17, 2003
06	The Enforcement of Accident Prevention Regulations	October 21, 2003
07	The Determination of Disability	October 21, 2003
08	The Measurement of Partial Disability	May 1, 2000
09	Publication of the Permanent Disability Evaluation Schedule	June 17, 2003
10	A Claim for Dependents Benefits	February 24, 2004
11	Communications with Unions in Matters of Safety and Health	October 21, 2003
12	A Claim to a Solicitor's Lien	June 17, 2003
13	The Provision of Rehabilitation Services	June 17, 2003
14	Rehabilitation and Re-training	May 1, 2000
15	Industrial Hygiene and Cominco Ltd.	October 21, 2003
16	*The Criminal Injuries Compensation Act*	October 21, 2003
17	Disablement Following Unauthorized Surgery	February 24, 2004
18	Dependent's Allowances	June 17, 2003
19	Industrial Hygiene and Cominco Ltd.	June 17, 2003
20	The Payment of Claims Pending Appeals by Employers	October 21, 2003
21	The Re-opening of a Commuted Pension	October 21, 2003

DECISION NO.	TITLE	RETIREMENT DATE
22	The Measurement of Partial Disability	May 1, 2000
23	A Penalty Assessment	October 21, 2003
24	The Revision of Appeal Procedures	May 1, 2000
25	Boards of Review	June 17, 2003
26	Coverage of Workmen's Compensation	January 1, 2003
27	An Application for Re-Opening	June 17, 2003
28	Oral Enquiries on Appeals to the Commissioners	May 1, 2000
29	The Re-Opening of Decisions	October 21, 2003
30	A Claim for Death by Suicide	June 17, 2003
31	Unemployment Insurance Benefits	June 17, 2003
32	The Employment Relationship (Taxis)	January 1, 2003
33	The Measurement of Partial Disability and Proportionate Entitlements	May 1, 2000
34	The Accident Prevention Regulations and the Prosecution of Workers	October 21, 2003
35	Procedure on Appeals	June 17, 2003
36	Industrial Hygiene	June 17, 2003
37	The Replacement of Eyeglasses	June 17, 2003
38	Compensation for Loss of Hearing	June 17, 2003
39	The Coverage of Workmen's Compensation	October 21, 2003
40	The Calculation of Compensation and Recurrence of Disability	June 17, 2003
41	The Composition of a Medical Review Panel	February 24, 2004
42	Changes in the *Workmen's Compensation Act*	June 17, 2003
43	The *Workmen's Compensation Amendment Act*	May 1, 2000

DECISION NO.	TITLE	RETIREMENT DATE
44	The Recurrence of Disability	October 21, 2003
45	Claims for Silicosis	June 17, 2003
46	The Consumer Price Index	May 1, 2000
47	The Commencement of the *Workmen's Compensation Amendment Act*, 1974	June 17, 2003
48	The Coverage of Workers' Compensation	February 24, 2004
49	The Coverage of Workers' Compensation	January 1, 2003
50	The Coverage of Workers' Compensation	February 24, 2004
51	A Penalty Assessment and Northwood Properties Ltd.	June 17, 2003
52	Evidence and the Standard of Proof	October 21, 2003
53	Fire Fighting and Hair	June 17, 2003
54	The Reimbursement of Expenses	October 21, 2003
55	Rehabilitation and Re-training	May 1, 2000
56	Rehabilitation Provisions for a Surviving Dependent Spouse	June 17, 2003
57	The Termination of Benefits at a Future Date	June 17, 2003
58	Industries and Classifications	January 1, 2003
59	Lump Sums in Fatal Cases	October 21, 2003
60	Appeals to Boards of Review	October 21, 2003
61	Employers' Reports of Injuries	June 17, 2003
62	Rehabilitation and Re-training	October 21, 2003
63	The Supply of In-File Information	June 17, 2003
64	Pensions for Widows aged 40 to 49 years	June 17, 2003
65	Cost Shifting Between Classes	February 24, 2004

DECISION NO.	TITLE	RETIREMENT DATE
66	Boards of Review	June 17, 2003
67	The Commutation of Pensions	May 1, 2000
68	The Maximum Wage Rate	May 1, 2000
69	Legal Fees	February 24, 2004
70	Boards of Review	October 21, 2003
71	The Industrial Hygiene Regulations	June 17, 2003
72	The Reinstatement of Pensions	June 17, 2003
73	Transcripts of Interviews	May 1, 2000
74	Unborn Children	June 17, 2003
75	Canada Pension Plan Benefits	June 17, 2003
76	Dependents Resident Abroad	June 17, 2003
77	Criminal Injuries Compensation	February 24, 2004
78	Multiple Disabilities and the Determination of the Maximum	June 17, 2003
79	Time Limit on Appeals	May 1, 2000
80	Safety Head Gear	October 21, 2003
81	The Recurrence of Disability	June 17, 2003
82	The Consumer Price Index	May 1, 2000
83	Cost of Living Increases and Commutations	October 21, 2003
84	Industrial Noise	June 17, 2003
85	Funeral Expenses	June 17, 2003
86	Disablement from Vibrations	October 21, 2003
87	A Common-Law Wife	October 21, 2003

DECISION NO.	TITLE	RETIREMENT DATE
88	The Application of Consumer Price Index Increases to Re-Instated Pensions under section 25A	June 17, 2003
89	Personal Care Allowances	May 1, 2000
90	A Common-Law Wife	June 17, 2003
91	Boards of Review and the Pension Plan	May 1, 2000
92	Allowances to Claimants	May 1, 2000
93	Industrial Diseases	June 17, 2003
94	Industrial Diseases	May 1, 2000
95	The Measurement of Partial Disability	October 21, 2003
96	Appeal Procedures	June 17, 2003
97	The Charging of Costs for Injuries Occurring in Connection with Treatment	October 21, 2003
98	Remarriage Allowances	May 1, 2000
100	Inspection Visits	June 17, 2003
101	Contagious Diseases	February 24, 2004
102	Disablement Through Exhaustion	February 24, 2004
103	Safety Awards	June 17, 2003
104	The Commutation of Pensions	June 17, 2003
105	The Future Employment of a Worker Disabled by a Compensable Injury of Industrial Disease	June 17, 2003
106	A One-Man Company	May 1, 2000
107	Termination Pay	February 24, 2004
108	The Violation of Safety Regulations by a Worker	February 24, 2004
109	The Dual System of Measurement for Injuries Involving the Spinal Column	June 17, 2003

DECISION NO.	TITLE	RETIREMENT DATE
110	Emphysema and Bronchitis	October 21, 2003
111	A Penalty for Non-Registration	January 1, 2003
112	The Consumer Price Index	May 1, 2000
113	Hearing Aids	June 17, 2003
114	Cost Shifting Between Classes	October 21, 2003
115	Employment Injuries and Natural Causes	October 21, 2003
116	The Coverage of Independent Operators	January 1, 2003
117	Adjustments According to the Consumer Price Index	May 1, 2000
118	Remarriages Allowances	May 1, 2000
119	Medical Information	May 1, 2000
120	The Coverage of Workers' Compensation and Participation in Competitions	June 17, 2003
121	Employment Injuries and Natural Causes	February 24, 2004
122	Industrial Disease	June 17, 2003
123	Changes in the *Workers Compensation Act*	May 1, 2000
124	Intoxication and Claims	October 21, 2003
125	The Commencement of *Workers Compensation Amendment Act, 1975*	May 1, 2000
126	Compensation Coverage and a Captive Road	October 21, 2003
127	Boards of Review	October 21, 2003
128	Bronchitis and Emphysema	February 24, 2004
129	Injuries and "Specific Incidents"	February 24, 2004
130	The Review of Old Disability Pensions	June 17, 2003
131	*The Criminal Injuries Compensation Act*	October 21, 2003

DECISION NO.	TITLE	RETIREMENT DATE
132	*The Criminal Injuries Compensation Act*	October 21, 2003
133	*The Criminal Injuries Compensation Act*	October 21, 2003
134	The Payment of Damages to a Worker and Subsequent Compensation Benefits	October 21, 2003
135	Compensation Decisions and the Death of the Worker	June 17, 2003
136	Compensation for Hearing Loss	May 1, 2000
137	Compensation for Hearing Loss	June 17, 2003
138	The Employment Relationship	January 1, 2003
139	Medical Aid Contracts	June 17, 2003
140	The Time Limit for Claiming Compensation	October 21, 2003
141	A One-Man Company	May 1, 2000
142	Employment Injuries and Natural Causes	October 21, 2003
143	The Maximum Wage Rate	May 1, 2000
144	The Management Role in Health and Safety	October 21, 2003
145	Employment Injuries and Natural Causes	February 24, 2004
146	An Unmarried Mother and Child	October 21, 2003
147	Health and Safety Awards	June 17, 2003
148	The Course of Employment	June 17, 2003
149	Commercial Stock Audits	January 1, 2003
150	Compensation for Compulsory Lay-off to Prevent the Carriage of Infection	October 21, 2003
151	The Apportionment of Dependents' Allowances	June 17, 2003
152	Injuries Arising out of Treatment and Other Appointments	February 1, 2004
153	Compensation Coverage for Volunteers	May 1, 2000

DECISION NO.	TITLE	RETIREMENT DATE
154	Legal Services for Rehabilitation Purposes	May 1, 2000
155	The Commutation of Pensions	May 1, 2000
156	The Review of Old Disability	June 17, 2003
157	Sexual Impotence	October 21, 2003
158	The Uses and Limitations of Sanctions in Industrial Health and Safety	October 21, 2003
159	The Consumer Price Index	May 1, 2000
160	The Calculation of Projected Loss of Earnings	May 1, 2000
161	Compensation Coverage for Volunteers	January 1, 2003
162	Personal Acts for an Employer	October 21, 2003
163	The Fishing Industry	January 1, 2003
164	Compensation for Hearing Loss	June 17, 2003
165	Compensation Coverage for Trainees	January 1, 2003
166	Adjustments According to the Consumer Price Index	May 1, 2000
167	Industrial Hygiene	June 17, 2003
168	The Disclosure of Information on Claim Files	May 1, 2000
169	An Employer or Independent Operator	January 1, 2003
170	The Fishing Industry	January 1, 2003
171	Allowances to Claimants	May 1, 2000
172	*The Criminal Injury Compensation Act*	February 24, 2004
173	*The Criminal Injury Compensation Act*	October 21, 2003
174	Time for Appeals	May 1, 2000
175	The Reimbursement of Expenses	May 1, 2000

DECISION NO.	TITLE	RETIREMENT DATE
176	The Binding Effects of Medical Review Certificates	October 21, 2003
177	Medical Research	June 17, 2003
178	*The Criminal Injury Compensation Act*	February 24, 2004
179	*The Criminal Injury Compensation Act*	October 21, 2003
180	Pollution	June 17, 2003
181	*The Criminal Injury Compensation Act*	October 21, 2003
182	The Course of Employment	February 24, 2004
183	An Employer or an Independent Operator	January 1, 2003
184	Application of the Dual System	May 1, 2000
185	Disability Assessment	October 21, 2003
186	Industrial Hygiene and Cominco Ltd.	June 17, 2003
187	The Fishing Industry	January 1, 2003
188	The Course of Employment	June 17, 2003
189	Broken Glass Claims	June 17, 2003
190	The Coverage of Workers Compensation	June 17, 2003
191	The Consumer Price Index	May 1, 2000
192	Industrial Hygiene and Cominco Ltd.	June 17, 2003
193	Adjustments According to the Consumer Price Index	May 1, 2000
194	Horseplay	February 24, 2004
195	Compensable Consequences of Work Injuries	February 24, 2004
196	Boards of Review	May 1, 2000
197	The Re-Opening of Board of Review Decisions	June 17, 2003
198	*The Criminal Injury Compensation Act*	February 24, 2004

DECISION NO.	TITLE	RETIREMENT DATE
199	The Review of Old Disability Pensions	June 17, 2003
200	Subsistence	October 21, 2003
201	Payments of Claims Pending Appeals to the Commissioners	May 1, 2000
202	Dual System of Measuring Disability	May 1, 2000
203	Legal Services for Rehabilitation Purposes	June 17, 2003
204	The Maximum Wage Rate	May 1, 2000
205	Rheumatoid Arthritis	October 21, 2003
206	Allergy Due to Red Cedar Dust	October 21, 2003
207	Bronchitis and Emphysema	February 24, 2004
208	The Awarding of Costs	October 21, 2003
209	Lunch Breaks	June 17, 2003
210	Re-Openings and New Evidence	June 17, 2003
211	The Reimbursement of Expenses	May 1, 2000
212	Commutation of Pensions	May 1, 2000
213	Bunkhouses	June 17, 2003
214	Travelling Employees	February 24, 2004
215	Consulting Firms	January 1, 2003
216	The Consumer Price Index	May 1, 2000
217	Adjustments According to the Consumer Price Index	May 1, 2000
218	Commutation of Pensions	May 1, 2000
219	Medical Review Panels	February 24, 2004
220	Proportionate Entitlement and the Dual System	May 1, 2000
221	Bronchitis and Emphysema	October 21, 2003

DECISION NO.	TITLE	RETIREMENT DATE
222	Compensable Consequences of Work Injuries	October 21, 2003
223	The Fishing Industry	January 1, 2003
224	The Fishing Industry	January 1, 2003
225	The Fishing Industry	April 1, 2006
226	The Fishing Industry	January 1, 2003
227	Broken Eyeglasses	October 21, 2003
228	Multiple Sclerosis	June 17, 2003
229	Industries and Employment	January 1, 2003
230	Unauthorized Activities	October 21, 2003
232	Cancer of Gastro-Intestinal Tract	June 17, 2003
233	Security and Investigation Services	May 1, 2000
234	Occupational Hygiene and Cominco Ltd.	June 17, 2003
235	Manpower Supply Agencies	January 1, 2003
236	Interim Adjudication	June 17, 2003
237	Complaints to the Commissioners in Respect of Compensation Claims	May 1, 2000
238	Bronchitis and Emphysema	October 21, 2003
239	Ganglia	October 21, 2003
240	Training Allowances	June 17, 2003
241	Inmates on Work Release Programmes	January 1, 2003
242	Supply of Appliances	October 21, 2003
243	Industrial Diseases	June 17, 2003
244	The Consumer Price Index	May 1, 2000
245	Adjustments According to the Consumer Price Index	May 1, 2000
246	Pulmonary Disease and “Hard Metal” Grinding	June 17, 2003

DECISION NO.	TITLE	RETIREMENT DATE
247	Workers Undergoing Custodial Care	June 17, 2003
248	Class 11	May 1, 2000
249	Recurrence of Disability	May 1, 2000
250	Industrial Diseases	June 17, 2003
251	Penalties under Section 61(2)	October 21, 2003
252	Scope of Employment	October 21, 2003
253	Replacement of Eyeglasses and Wage Loss	June 17, 2003
254	Payment of Claims Pending Appeals to the Commissioners	May 1, 2000
255	Registration of Labour Contractors as Employers	January 1, 2003
256	Scope of Employment	June 17, 2003
257	The Maximum Wage Rate	May 1, 2000
258	The Reimbursement of Expenses	May 1, 2000
259	Common-Law Spouses – “Re-Marriage Allowance”	June 17, 2003
260	Enhancement Factors and Multiple Disabilities	October 21, 2003
261	Temporary Partial Disability	June 17, 2003
262	Disability and Unemployability	June 17, 2003
263	Appeals to Medical Review Panels	October 21, 2003
264	Compensation Payable when Company Unregistered	May 1, 2000
265	The Consumer Price Index	May 1, 2000
266	Adjustments According to the Consumer Price Index	May 1, 2000
267	Section 7A: Compensation for Non-Traumatic Hearing Loss	February 24, 2004

DECISION NO.	TITLE	RETIREMENT DATE
268	Industrial Hygiene and Cominco Ltd.	June 17, 2003
269	Appeal Against Penalty Levy Amounting to $13,649.37	June 17, 2003
270	Subsection 6(5) Proportionate Entitlement	February 24, 2004
271	Re: Subsection 37(1)(e) – Charging of Costs for Enhanced Disabilities	March 1, 2005
272	Commutations	May 1, 2000
273	School Teachers and Scope of Employment	October 21, 2003
274	Industrial Hygiene and Cominco Ltd.	June 17, 2003
275	Claim for Dependent Benefits	June 17, 2003
276	Compensation for Unauthorized Surgery	June 17, 2003
277	The Consumer Price Index	May 1, 2000
278	Adjustments According to the Consumer Price Index	May 1, 2000
279	Average Earnings and Projected Loss of Earnings	October 21, 2003
280	Appeals & Referrals to the Commissioners	May 1, 2000
281	Re-Opening of Decisions & Time Limits on Appeals	June 17, 2003
282	Sections 50 and 52	October 21, 2003
283	Scope of Employment	June 17, 2003
284	The Maximum Wage Rate	May 1, 2000
285	The Reimbursement of Expenses	May 1, 2000
286	Section 6(1): Injuries Arising out of Employment	February 24, 2004
287	Proportionate Entitlement and Dual System	May 1, 2000
288	The Review of Old Disability Pensions	June 17, 2003
289	Permanent Partial Disability and Devaluation	October 21, 2003

DECISION NO.	TITLE	RETIREMENT DATE
290	The Consumer Price Index	May 1, 2000
291	Adjustments According to the Consumer Price Index	May 1, 2000
292	Scope of Employment and Sports Professionals	June 17, 2003
293	Section 54 and Refusal of Medical Examination or Treatment	October 21, 2003
294	Payment of Costs for Medical Review Reports and Examinations	June 17, 2003
295	Section 54(2)(a) Insanitary or Injurious Practices	June 17, 2003
296	Section 8 – Employment out of Province	June 17, 2003
297	Dual System and Non-Spinal Injuries	May 1, 2000
298	Appeals to Medical Review Panels	June 17, 2003
299	Hearing Aids	June 17, 2003
300	Section 52 - “Special Circumstances”	May 1, 2000
301	Single Trauma and Cancer	June 17, 2003
302	Termination and Wage Loss Benefits	June 17, 2003
303	Access to Claim Files	May 1, 2000
304	The Consumer Price Index	May 1, 2000
305	Adjustments According to the Consumer Price Index	May 1, 2000
306	Selective Employment	October 21, 2003
307	The Fishing Industry	January 1, 2003
308	The Maximum Wage Rate	May 1, 2000
309	The Reimbursement of Expenses	May 1, 2000
310	Commutation of Hearing Loss Pensions	May 1, 2000
311	Commutation of Pensions	May 1, 2000

DECISION NO.	TITLE	RETIREMENT DATE
312	Transportation Costs for Physiotherapy and the Reimbursement of Expenses	June 17, 2003
313	Overpayments	June 17, 2003
314	The Consumer Price Index	May 1, 2000
315	Adjustments According to the Consumer Price Index	May 1, 2000
316	Herniae	October 21, 2003
317	Industrial Hygiene and Cominco Ltd.	June 17, 2003
318	Stress Testing	February 24, 2004
319	Clothing Allowances	May 1, 2000
320	Continuity of Income and Assessment for Permanent Disability	February 24, 2004
321	*Workers Compensation Act*	May 1, 2000
322	The Consumer Price Index	May 1, 2000
323	Adjustments According to the Consumer Price Index	May 1, 2000
324	Personal Care Allowances	February 24, 2004
325	The Review of Old Disability Pensions	June 17, 2003
326	Industrial Diseases	October 21, 2003
327	The Maximum Wage Rate	May 1, 2000
328	The Reimbursement of Expenses	May 1, 2000
329	Industrial Health and Safety Regulations	June 17, 2003
330	Scope of Employment	February 24, 2004
331	The Consumer Price Index	May 1, 2000
332	Adjustments According to the Consumer Price Index	May 1, 2000
333	Certain Industrial Diseases	February 24, 2004

DECISION NO.	TITLE	RETIREMENT DATE
334	Boards of Review	June 17, 2003
335	Principals of Limited Companies	January 1, 2003
336	The Consumer Price Index	May 1, 2000
337	Adjustments According to the Consumer Price Index	May 1, 2000
338	Disclosure of Claim Files	May 1, 2000
339	The Maximum Wage Rate	May 1, 2000
340	The Reimbursement of Expenses	May 1, 2000
341	Industrial Hygiene and Cominco Ltd.	June 17, 2003
342	Assessment of Employers	May 1, 2000
343	Scope of Employment	June 1, 2004
344	The Consumer Price Index	May 1, 2000
345	Adjustments According to the Consumer Price Index	May 1, 2000
346	Payment of Interest	May 1, 2000
347	Oral Hearings on Appeals to the Commissioners	May 1, 2000
348	Alcoholism	February 24, 2004
349	Industrial Health and Safety Regulations	October 21, 2003
350	Commissioners' Decisions	May 1, 2000
351	Assessment of Employers	January 1, 2003
352	The Consumer Price Index	May 1, 2000
353	Adjustments According to the Consumer Price Index	May 1, 2000
354	Industrial Hygiene and Cominco Ltd.	June 17, 2003
355	Industrial Health and Safety Inspections	October 21, 2003

DECISION NO.	TITLE	RETIREMENT DATE
356	Bilateral Herniae	October 21, 2003
357	Subsistence and the Reimbursement of Expenses	June 17, 2003
358	The Maximum Wage Rate	May 1, 2000
359	The Reimbursement of Expenses	May 1, 2000
360	Out of Province Injury and Travelling to Work	October 21, 2003
361	Coverage of the Farming Industry	May 1, 2000
362	The Maximum Wage Rate	May 1, 2000
363	The Review of Old Disability Pensions	October 21, 2003
364	Retraining of Surviving Spouses	May 1, 2000
365	The Consumer Price Index	May 1, 2000
366	Adjustments According to the Consumer Price Index	May 1, 2000
367	Hearing Aids	June 17, 2003
368	Appeals	June 17, 2003
369	Appeals to Boards of Review	October 21, 2003
370	Disclosure of Board Files	May 1, 2000
371	Publication of Board Manuals	January 1, 2003
372	The Consumer Price Index	May 1, 2000
373	Adjustments According to the Consumer Price Index	May 1, 2000
374	Appeals to the Commissioners	May 1, 2000
375	The Maximum Wage Rate	May 1, 2000
376	The Reimbursement of Expenses	May 1, 2000
377	Fraudulent Claims	June 17, 2003

DECISION NO.	TITLE	RETIREMENT DATE
378	Proportionate Entitlement	October 21, 2003
379	Time Limit on Application for Compensation	February 24, 2004
380	The Consumer Price Index	May 1, 2000
381	Adjustments According to the Consumer Price Index	May 1, 2000
382	The Commutation of Pensions	February 24, 2004
383	Application of Dual System	June 17, 2003
384	Interest Payments on Retroactive Pensions	October 21, 2003
385	The Consumer Price Index	May 1, 2000
386	Adjustments According to the Consumer Price Index	May 1, 2000
387	Chiropractic Treatment	June 17, 2003
388	Assignments, Charges, or Attachments of Compensation	June 17, 2003
389	Refusals of Certificates of Fitness Under the Mines Act	May 1, 2000
390	The Maximum Wage Rate	May 1, 2000
391	The Reimbursement of Expenses	May 1, 2000
392	The Consumer Price Index	May 1, 2000
393	Appeals	May 1, 2000
394	The Dual System of Measuring Disability	October 21, 2003
395	Payments Pending Appeals	June 17, 2003
396	The Consumer Price Index	May 1, 2000
397	The Maximum Wage Rate	May 1, 2000
398	The Consumer Price Index	May 1, 2000

DECISION NO.	TITLE	RETIREMENT DATE
399	Appeals to Workers' Compensation Review Board	June 17, 2003
400	The Consumer Price Index	May 1, 2000
401	Experience Rating	January 1, 2003
402	Adjustments According to the Consumer Price Index	May 1, 2000
403	Appeals to Workers' Compensation Review Board	May 1, 2000
404	The Maximum Wage Rate	May 1, 2000
405	The Consumer Price Index	May 1, 2000
406	Recurrence of Disabilities	October 21, 2003
407	Assessment of Permanent Disabilities	February 24, 2004
408	The Consumer Price Index	May 1, 2000
409	The Maximum Wage Rate	May 1, 2000
410	Disclosure of Board Files	May 1, 2000
411	The Consumer Price Index	May 1, 2000
412	The Consumer Price Index	May 1, 2000
413	The Maximum Wage Rate	May 1, 2000
414	The Consumer Price Index	May 1, 2000
415	The Consumer Price Index	May 1, 2000
416	The Maximum Wage Rate	May 1, 2000
417	Adjustments According to the Consumer Price Index	May 1, 2000
418	The Consumer Price Index	May 1, 2000
419	Schedule B	June 17, 2003
420	The Consumer Price Index	May 1, 2000

DECISION NO.	TITLE	RETIREMENT DATE
421	The Maximum Wage Rate	May 1, 2000
422	The Consumer Price Index	May 1, 2000
423	Adjustments According to the Consumer Price Index	May 1, 2000

APPENDIX 2

OCCUPATIONAL DISEASES LISTED IN SCHEDULE B – #26.01

SECTION 6(4)

DESCRIPTION OF DISEASE	DESCRIPTION OF PROCESS OR INDUSTRY
1. Poisoning by:	
(a) Lead	Where there is an exposure to lead or lead compounds.
(b) Mercury	Where there is an exposure to mercury or mercury compounds.
(c) Arsenic or arsine	Where there is an exposure to arsenic or arsenic compounds.
(d) Cadmium	Where there is an exposure to cadmium or cadmium compounds.
(e) Manganese	Where there is an exposure to manganese or manganese compounds.
(f) Phosphorus, phosphine or due to the anti-cholinesterase action of organic phosphorus compounds.	Where there is an exposure to phosphorus or phosphorus compounds.
(g) Organic solvents (n-hexane, carbon tetrachloride, trichloroethane, trichloro-ethylene, acetone, benzene, toluene, xylene and others)	Where there is exposure to organic solvents.

(h)	Carbon monoxide	Where there is exposure to products of combustion, or any other source of carbon monoxide.
(i)	Hydrogen sulphide	Where there is excessive exposure to hydrogen sulphide.
(j)	Nitrous fumes (including silo-filler's disease)	Where there is excessive exposure to nitrous fumes including the oxides of nitrogen.
(k)	Nitriles, hydrogen cyanide or its soluble salts	Where there is exposure to chemicals containing -CN group including certain pesticides.
(l)	Phosgene	Where there is excessive exposure to phosgene including its occurrence as a breakdown product of chlorinated compounds by combustion.
(m)	Other toxic substances	Where there is exposure to such toxic gases, vapours, mists, fumes or dusts.

2. Infection caused by:

(a)	Psittacosis virus	Where there is established contact with ornithosis-infected avian species or material.
(b)	Staphylococcus aureus, Salmonella organisms, Hepatitis B virus	Employment where close and frequent contact with a source or sources of the infection has been established and the employment necessitates: (1) the treatment, nursing or examination of or interviews with patients or ill persons; or

		(2) the analysis or testing of body tissues or fluids; or (3) research into salmonellae, pathogenic staphylococci or Hepatitis B virus.
(c)	Brucella organisms (Undulant fever)	Where there is contact with animals, carcasses or animal by-products.
(d)	Tubercle bacillus	Employment where close and frequent contact with a source or sources of tuberculous infection has been established and the employment necessitates: (1) the treatment, nursing or examination of patients or ill persons: or (2) the analysis or testing of body tissues or fluids; or (3) research into tuberculosis by a worker who: (i) when first engaged, or, after an absence from employment of the types mentioned in these regulations for a period of more than one year, when re-engaged in such employment, was free from evidence of tuberculosis; and (ii) continued to be free from evidence of tuberculosis for 6 months after being so employed (except in primary tuberculosis as proven by a negative tuberculin test at time

		of employment). In the case of an employee previously compensated for tuberculosis, any subsequent tuberculosis after the disease has become inactive and has remained inactive for a period of three years or more shall not be deemed to have occurred as a result of the original disability for the purpose of the Act, unless the worker is still engaged in employment listed above or the Board is satisfied that the subsequent tuberculosis is the direct result of the tuberculosis for which the worker has been compensated.
3. Pneumoconiosis:		
	(a) Silicosis	Where there is exposure to airborne silica dust including metalliferous mining and coal mining.
	(b) Asbestosis	Where there is exposure to airborne asbestos dust.
	(c) Other pneumoconioses	Where there is exposure to the airborne dusts of coal, beryllium, tungsten carbide, aluminum or other dusts known to produce fibrosis of the lungs.

3A. Diffuse pleural thickening or fibrosis, whether unilateral or bilateral	Where there is exposure to airborne asbestos dust and the claimant has not previously suffered and is not currently suffering collagen disease,chronic uremia, drug-induced fibrosis, tuberculosis or other infection, trauma, or disease capable of causing pleural thickening or fibrosis.
3B. Benign pleural effusion, whether unilateral or bilateral	Where there is exposure to airborne asbestos dust and the claimant has not previously suffered and is not currently suffering collagen disease, chronic uremia, tuberculosis or other infection, trauma, or disease capable of causing pleural effusion.
4. Cancer:	
(a) Carcinoma of the lung when associated with:	
(i) asbestosis	Where there is exposure to airborne asbestos dust.
or	
(ii) bilateral diffuse pleural thickening or fibrosis, over 5 mm thick and extending over more than a quarter of the chest wall	Where there is exposure to airborne asbestos dust and the claimant has not previously suffered collagen disease, chronic uremia, drug-induced fibrosis, tuberculosis or other infection or trauma capable of causing pleural thickening or fibrosis.
(b) Mesothelioma (pleural or peritoneal)	Where there is exposure to airborne asbestos dust.
(c) Carcinoma of the larynx or pharynx associated with asbestosis	Where there is exposure to airborne asbestos dust.

(d)	Gastro-intestinal cancer (including all primary cancers associated with the oesophagus, stomach, small bowel, colon and rectum excluding the anus, and without regard to the site of the cancer in the gastro-intestinal tract or the histological structure of the cancer)	Where there is exposure to asbestos dust if during the period between the first exposure to asbestos dust and the diagnosis of gastro-intestinal cancer there has been a period of, or periods, adding up to, 20 years of continuous exposure to asbestos dust and such exposure represents or is a manifestation of the occupational activity in which it occurred.
(e)	Primary cancer of the lung	Where there is prolonged exposure to: (1) aerosols and gases containing arsenic, chromium, nickel or their compounds; or (2) bis (chloromethyl) ether; or (3) the dust of uranium, or radon gas and its decay products; or (4) particulate polycyclic aromatic hydrocarbons.
(f)	Leukemia or pre-leukemia	Where there is prolonged exposure to benzene or to ionizing radiation.
(g)	Primary cancer of the skin	Where there is prolonged contact with coal tar products, arsenic or cutting oils or prolonged exposure to solar ultra-violet light.
(h)	Primary cancer of the epithelial lining of the urinary bladder, ureter or renal pelvis	Where there is prolonged exposure to beta-naphthylamine, benzidine, or 4-nitrodiphenyl.

(i) Primary cancer of the mucous lining of the nose or nasal sinuses	Where there is prolonged exposure to dusts, fumes or mists containing nickel or the dusts of hard woods.
(j) Angiosarcoma of the liver	Where there is exposure to vinyl chloride monomer.
5. Repealed (BCReg 188/2000).	
6. Asthma	Where there is exposure to: (1) western red cedar dust; or (2) isocyanate vapours or gases; or (3) the dust, fume of vapours of other chemicals or organic material known to cause asthma.
7. Extrinsic allergic alveolitis (including farmers' lung and mushroom workers' lung)	Where there is repeated exposure to respirable organic dusts.
8. Acute upper respiratory inflammation, acute pharyngitis, acute laryngitis, acute tracheitis, acute bronchitis, acute pneumonitis, or acute pulmonary edema (excluding any allergic reaction, reaction to environmental tobacco smoke, or effect of an infection)	Where there is exposure to a high concentration of fumes, vapours, gases, mists, or dust of substances that have irritating or inflammatory properties, and the respiratory symptoms occur within 48 hours of the exposure, or within 72 hours where there is exposure to nitrogen dioxide or phosgene.
9. Metal fume fever	Where there is exposure to the fume of zinc or other metals.
10. Fluorosis	Where there is exposure to high concentrations of fluorine or fluorine compounds in gaseous or particulate form.
11. Neurosensory hearing loss	Where there is prolonged exposure to excessive noise levels.

12. Bursitis:	
(a) Knee bursitis (inflammation of the prepatellar, suprapatellar, or superficial infrapatellar bursa)…	Where there is repeated jarring impact against, or where there are significant periods of kneeling on, the affected knee.
(b) Shoulder bursitis (inflammation of the subacromial or subdeltoid bursa)…	Where there is frequently repeated or sustained abduction or flexion of the shoulder joint greater than sixty degrees and where such activity represents a significant component of the employment.
13. Tendinitis, tenosynovitis:	
(a) Hand-wrist tendinitis, tenosynovitis (including deQuervain's tenosynovitis)…	Where there is use of the affected tendon(s) to perform a task or series of tasks that involves any two of the following: (1) frequently repeated motions or muscle contractions that place strain on the affected tendon(s); (2) significant flexion, extension, ulnar deviation or radial deviation of the affected hand or wrist; (3) forceful exertion of the muscles utilized in handling or moving tools or other objects with the affected hand or wrist; and where such activity represents a significant component of the employment.

(b) Shoulder tendinitis…	Where there is frequently repeated or sustained abduction or flexion of the shoulder joint greater than sixty degrees and where such activity represents a significant component of the employment.
14. Decompression sickness	Where there is exposure to increased air pressure.
15. Contact dermatitis	Where there is excessive exposure to irritants, allergens or sensitizers ordinarily causative of dermatitis.
16. Hand-arm vibration syndrome	Where there have been at least 1000 hours of exposure to tools or equipment which cause the transfer of significant vibration to the hand or arm of the claimant.
17. Radiation injury or disease:	
(a) Due to ionizing radiation	Where there is exposure to ionizing radiation.
(b) Due to non-ionizing radiation:	
(i) conjunctivitis, keratitis	Where there is exposure to ultra-violet light.
(ii) cataract or other thermal damage to the eye.	Where there is excessive exposure to infra-red, microwave or laser radiation.
18. Erosion of incisor teeth	Where there is exposure to acid fumes or mist.

APPENDIX 3

This appendix has been deleted

APPENDIX 4

PERMANENT DISABILITY EVALUATION SCHEDULE – #39.10

For all section 23(1) assessments and reassessments undertaken with reference to the *Permanent Disability Evaluation Schedule* on or after August 1, 2003, please refer to the *Permanent Disability Evaluation Schedule* in Appendix 4 of Volume II and the appropriate policies in Chapter 6 of Volume II on the application of the *Schedule*.

EXPLANATION OF THE SCHEDULE

This is the Schedule used for guidance in the measurement of partial disability using the physical impairment method. The Schedule attributes a percentage of total disability to each of the specified disablements. For example, an amputation of the arm, middle, third of humerus, is indicated to be 65%. When that percentage rate is applied, it means that a claimant will receive by way of pension 65% of 75% of average earnings as determined by the Act.

The Schedule does not necessarily determine the rate of pension. The Board is free to take other factors into account. Thus, the Schedule provides a guideline or starting point for the measurement rather than providing a fixed result.

Only a minority of disabilities are listed in the Schedule. In other cases, however, a Schedule can still be of some guidance value if the injury is similar to one that is listed.

Where a claimant is over the age of 45 at the effective date of the award, the percentage rate is increased by 1% of the assessed disability for each year over 45 up to a maximum of 20% of the assessed disability. For example, if the claimant were aged 55 at the effective date of the award and the rate indicated in the Schedule for the particular disablement is 50%, the age adaptability factor would be 10% of 50%, making an overall disability rating of 55% of total disability.

UPPER EXTREMITY

	Percentage
(A) Amputations:	
1. Proximal, third of humerus or disarticulation at shoulder	70

		Percentage
2.	Middle, third of humerus	65
3.	Distal, third of humerus to biceps insertion	60
4.	Insertion of biceps to middle of forearm	55
5.	Middle of forearm to wrist	50
6.	Thumb, including metacarpal	20
7.	Thumb at M.P. joint	10
8.	Thumb at I.P. joint • one half of distal phalanx	4 2
9.	Thumb and index finger off at M.P. joints	24
10.	Thumb and middle finger off at M.P. joints	20
11.	Thumb and ring finger off at M.P. joints	15
12.	Thumb and little finger off at M.P. joints	15
13.	Fingers, four at M.P. joints	30
14.	Fingers, four at P.I.P. joints	18
15.	Fingers, four at D.I.P. joints	6
16.	Finger, index at M.P. joint	4
17.	Finger, index at P.I.P. joint	2.4
18.	Finger, index at D.I.P. joint	.8
19.	Finger, middle at M.P. joint	.4
20.	Finger, middle at P.I.P. joint	2.4
21.	Finger, middle at D.I.P. joint	.8
22.	Finger, ring at M.P. joint	2.5

		Percentage
23.	Finger, ring at P.I.P. joint	1.5
24.	Finger, ring at D.I.P. joint	.5
25.	Finger, little at M.P. joint	2.5
26.	Finger, little at P.I.P. joint	1.5
27.	Finger, little at D.I.P. joint	.5
28.	Metacarpals	Up to value of finger
29.	Fingers, index, middle and ring at the M.P. joints	22
30.	Fingers, index, middle and little at the M.P. joints	22
31.	Fingers, index, ring and little at the M.P. joints	19
32.	Fingers, middle, ring and little at the M.P. joints	19
33.	Fingers, index and middle at the M.P. joints	14
34.	Fingers, index and ring at the M.P. joints	11
35.	Fingers, index and little at the M.P. joints	11
36.	Fingers, middle and ring at the M.P. joints	11
37.	Fingers, middle and little at the M.P. joints	11
38.	Fingers, ring and little at the M.P. joints	8
39.	Fingers, two or more at the P.I.P. joints	3/5 combined value
40.	Fingers, two or more at the D.I.P. joints	1/5 combined value

		Percentage
(B)	Immobility of Joints:	
41.	Shoulder, complete with no scapular movement (so called frozen shoulder)	35
42.	Shoulder, gleno-humeral fusion, scapula free	20
43.	Shoulder, limited to 90º of abduction	5
44.	Elbow	20
45.	Wrist	12.5
46.	Pronation and supination complete in mid position	10
47.	Pronation alone	3
48.	Supination alone	5
49.	Thumb, fusion both joints	Up to 3/5 value of amputation at M.P. joint
50.	Thumb, fusion of M.P. or I.P. joints	To be assessed as a percentage impairment of Item No. 49
51.	Finger, all joints	Up to value of finger
52.	Finger, P.I.P. and D.I.P. joints	Up to 3/5 value of finger
53.	Finger, D.I.P. joint	Up to 1/5 value of finger

LOWER EXTREMITY

		Percentage
(A)	Amputations:	
54.	Hip disarticulation or short stump	65
55.	Thigh, sight of election or end bearing (requiring false knee joint)	50
56.	Short below knee stump suitable for conventional B.K. prosthesis	45
57.	Below knee, suitable for B.K. prosthesis (Patellar bearing)	35
58.	Leg, at ankle end bearing	25
59.	Through foot	10-25
60.	Toes, all toes	5
61.	Toes, great • with head of metatarsal	2.5 5
62.	Toes, great at distal	1
63.	Toes, other than great, each • metatarsal, each	.5 .5
64.	Toe, little with metatarsal	2

LOWER EXTREMITY IMMOBILITY

(B)	Immobility:	
65.	Hip	30
66.	Knee	25
67.	Knee, Flexion limited to 90º	5

			Percentage
68.	Ankle		12
69.	Great toe, both joints		2.5
70.	Great toe, distal		.5
71.	(a)	Talocalcaneal arthrodesis, up to	4.25
	(b)	Triple arthrodesis	7.0

(C) Shortening:

72.	(a)	2.5 cms	1.5
	(b)	5.0 cms	6.0
	(c)	7.5 cms	15.0

DENERVATION

73.	Median nerve complete at elbow	40
	Median nerve complete at wrist	20
74.	Ulnar nerve complete at elbow	10
	Ulnar nerve complete at wrist	8
75.	Peroneal, complete	10
76.	Femoral nerve	12.5

IMPAIRMENT OF VISION

77.	Enucleation	18
78.	Industrially blind, single eye	16
79.	Cataract or aphakia	12
80.	Double aphakia	20
81.	Hemianopia, right or left field	25

		Percentage
82.	Diplopia, all fields	10
83.	Scotomata, depending on location and extent	Up to 16

Loss of Visual Acuity:

84.	20/30	0
85.	20/40	1
86.	20/50	2
87.	20/60	4
88.	20/80	6
89.	20/100	8
90.	20/200 or poorer	16

IMPAIRMENT OF HEARING

Unilateral Hearing Loss:

91.	Difference of 20 dB average at 500 cps, 1000 cps and 2000 cps	1
92.	Difference of 30 dB average at 500 cps, 1000 cps and 2000 cps	2
93.	Difference of 40 dB average at 500 cps, 1000 cps and 2000 cps	3

Bilateral Hearing Loss:

94.	35 dB ANSI (25 ASA) in single ear	0.2
95.	40 dB ANSI (30 ASA) in single ear	0.3

		Percentage
96.	45 dB ANSI (35 ASA) in single ear	0.5
97.	50 dB ANSI (40 ASA) in single ear	0.7
98.	55 dB ANSI (45 ASA) in single ear	1.0
99.	60 dB ANSI (50 ASA) in single ear	1.3
100.	65 dB ANSI (55 ASA) in single ear	1.7
101.	70 dB ANSI (60 ASA) in single ear	2.1
102.	75 dB ANSI (65 ASA) in single ear	2.6
103.	80 dB ANSI (70 ASA) in single ear	3.0

SCHEDULE D

NON-TRAUMATIC HEARING LOSS

(Section 7)

104.	Complete loss of hearing in both ears	15.0
105.	Complete loss of hearing in one ear with no loss in the other	3.0

Loss of hearing in dbs measured in each ear in turn (ANSI)	Percentage of total disability Ear most affected	PLUS ear least affected
0 - 27	0	0
28 - 32	0.3	1.2
33 - 37	0.5	2.0
38 - 42	0.7	2.8
43 - 47	1.0	4.0
48 - 52	1.3	5.2
53 - 57	1.7	6.8

Loss of hearing in dbs measured in each ear in turn (ANSI)	Percentage of total disability Ear most affected PLUS ear least affected	
58 - 62	2.1	8.4
63 - 67	2.6	10.4
68 or more	3.0	12.0

Percentage

VISCERAL LOSS

106. Loss of Kidney 15

107. Loss of Spleen 10

THE SPINE

(Codified March 1, 1990)

This schedule recognizes that anatomical loss or damage resulting from injury or surgery may contribute to physical impairment of the spine. When anatomic and/or surgical impairment is present as well as loss of range of movement of the spine, the **final** impairment rating will be based on the greater of the two.

Range of movement of the spine is difficult to assess on a consistent basis because the joints of the spine are small, inaccessible and not externally visible. Only movement of a region of the spine can be measured; it is not possible to measure mobility of a single vertebra. Spine movement also varies with an individual's body type, age and general health. Because of these, a judgment factor will continue to be necessary in spine assessment.

Percentage

Cervical Spine:

108. (a) Compression fractures

(i) Up to 50% compression 0-2% impaired
(ii) Greater than 50% compression 2-4% impaired

		Percentage
(b)	Impairment resulting from surgical loss of intervertebral disc C1 to D1	0-2% per level
(c)	Ankylosis (fusion) C1 to D1 including surgical loss of intervertebral disc	3% per level

109. Loss of range of motion

Flexion	0-6%
Extension	0-3%
Lateral flexion right and left	each 0-2%
Rotation right and left	each 0-4%
Maximum impairment of function	not to exceed 21%

Dorsal Spine:

110. (a) Compression fractures

(i)	Up to 50% compression	0-1% impaired
(ii)	Over 50% compression	1-2% impaired
(b)	Impairment resulting from surgical loss of intervertebral disc D1 to D12	0-1% per level to a maximum of 6%
(c)	Ankylosis (fusion) D1 to D12 including surgical loss of intervertebral disc	1% per level to a maximum of 6%
	Maximum impairment of function	not to exceed 6%

			Percentage
Lumbar Spine:			
111.	(a)	Compression fractures to include D12	
		(i) Up to 50% compression	0-2%
		(ii) Over 50% compression	2-4%
	(b)	Impairment resulting from surgical loss of intervertebral disc D12 to S1	0-2% per level
	(c)	Ankylosis (fusion) D12 to S1 including surgical loss of intervertebral disc	4% per level
112.	Loss of range of motion		
		Flexion	0-7%
		Extension	0-3%
		Lateral flexion right and left	each 0-2%
		Rotation right and left	each 0-5%
	Maximum impairment of function		not to exceed 24%

Psychological Disability

The categories and descriptions are based on the American Medical Association *Guides to the Evaluation of Permanent Impairment* (4th Edition). The Board follows the principles of assessment set forth in that publication in assessing permanent psychological impairment.

113	**Aphasia and Communication Disturbances**	**%**
(a)	Mild - minimal disturbance in comprehension and production of language symbols of daily living	0-25%
(b)	Moderate - moderate disturbance in comprehension and production of language symbols of daily living	30-70%
(c)	Marked - inability to comprehend language symbols. Production of unintelligible or inappropriate language for daily activities	75-95%
(d)	Extreme - complete inability to communicate or comprehend language symbols	100%
114	**Disturbances of Mental Status and Integrative Functioning**	
(a)	Mild - some impairment but ability remains to satisfactorily perform most activities of daily living	0-25%
(b)	Moderate - impairment necessitates direction and supervision of daily living activities	30-70%
(c)	Marked - impairment necessitates directed care under continued supervision and confinement in home or other facility	75-95%
(d)	Extreme - individual is unable without supervision to care for self and be safe in any situation	100%
115	**Emotional (Mental) and Behavioural Disturbances** The impairment levels below relate to activities of daily living, social functioning, concentration, and adaptation	
(a)	Mild - impairment levels are compatible with most useful functioning	0-25%
(b)	Moderate - impairment levels are compatible with some, but not all useful functioning	30-70%
(c)	Marked - impairment levels significantly impede useful functioning	75-95%
(d)	Extreme - impairment levels preclude most useful functioning	100%

Disability ratings greater than 0% are made in 5% increments.

CHART 1

THUMB OR SINGLE FINGER

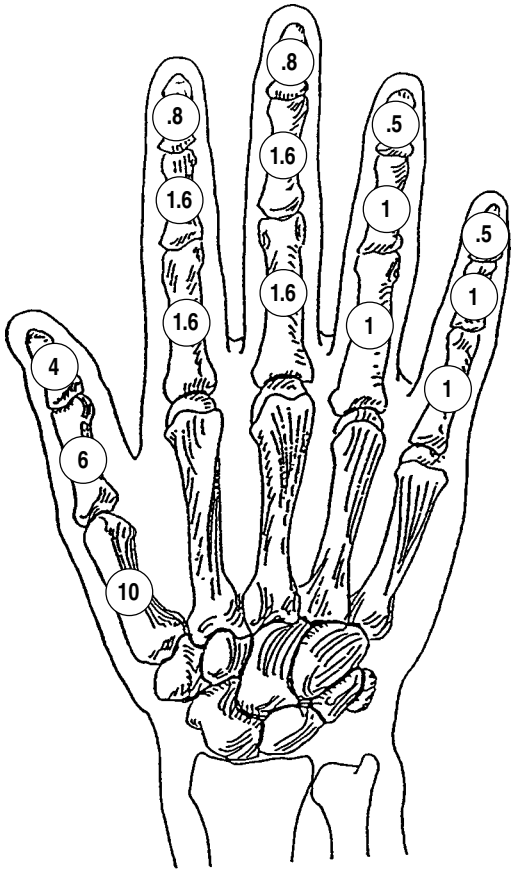


CHART 2

INDEX AND MIDDLE

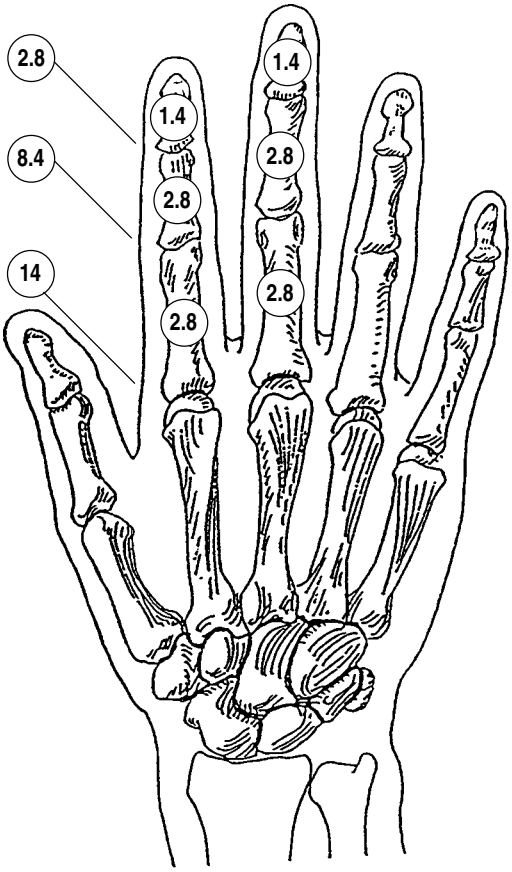


CHART 3

INDEX AND RING

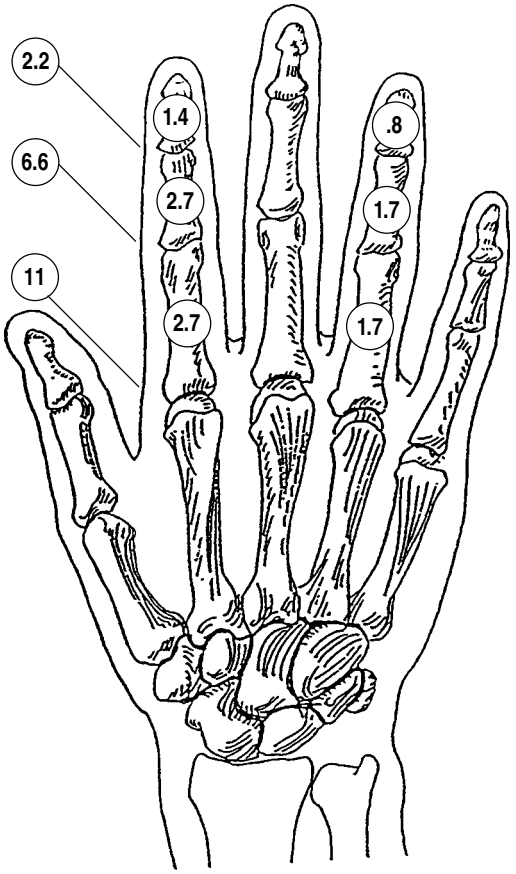


CHART 4

INDEX AND LITTLE

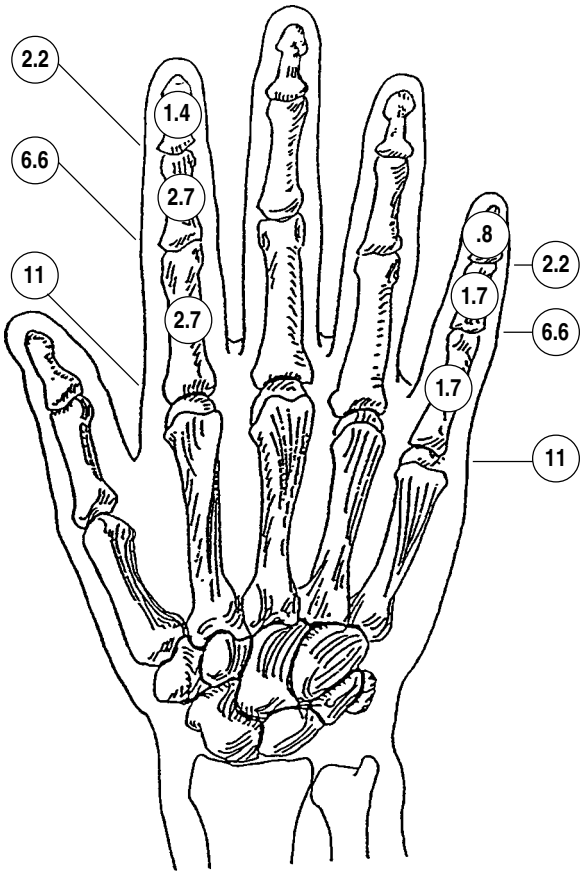


CHART 5

MIDDLE AND RING

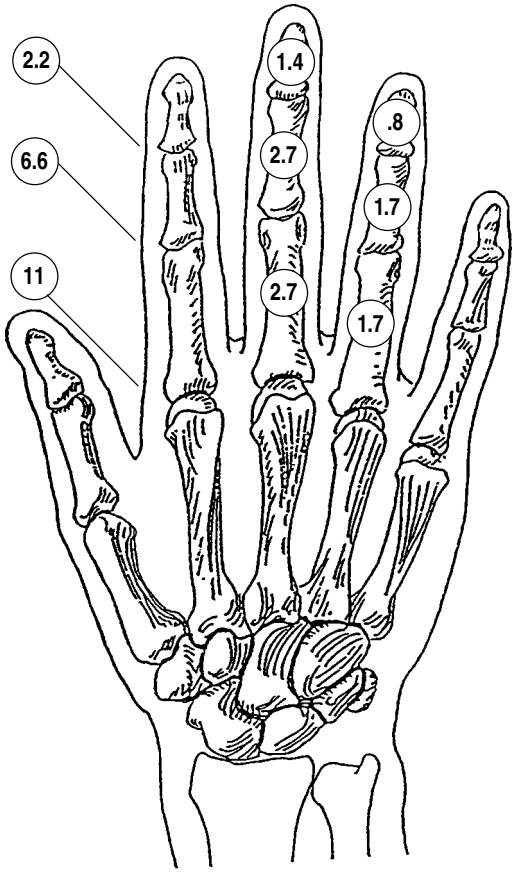


CHART 6

MIDDLE AND LITTLE

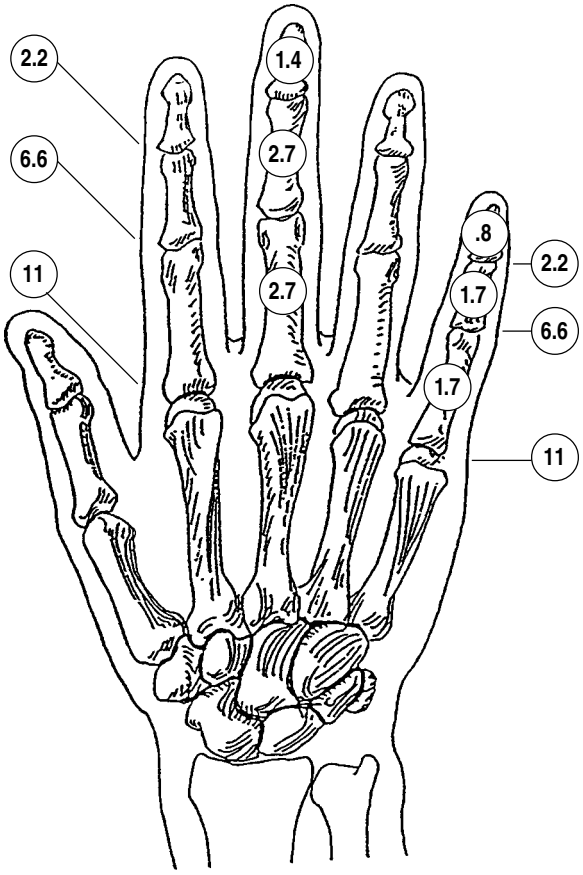


CHART 7

RING AND LITTLE

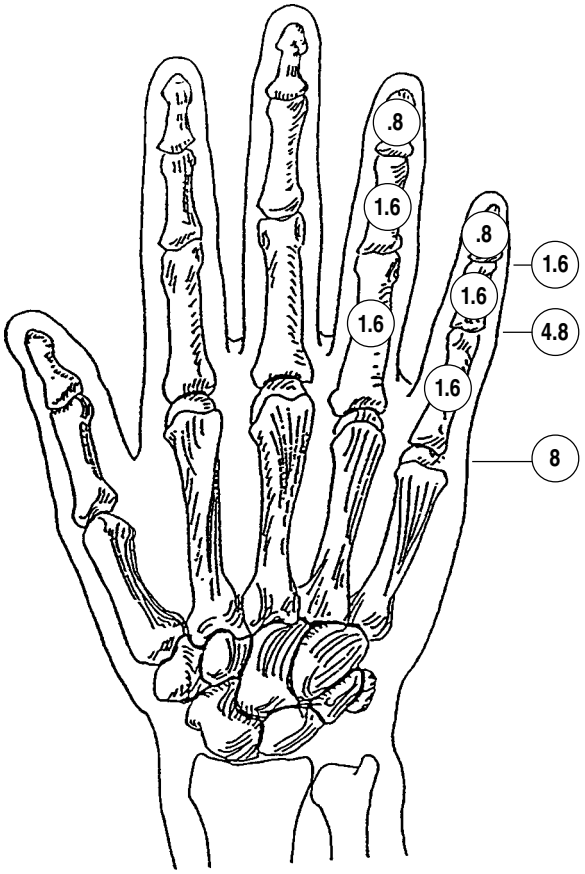


CHART 8

INDEX, MIDDLE AND RING

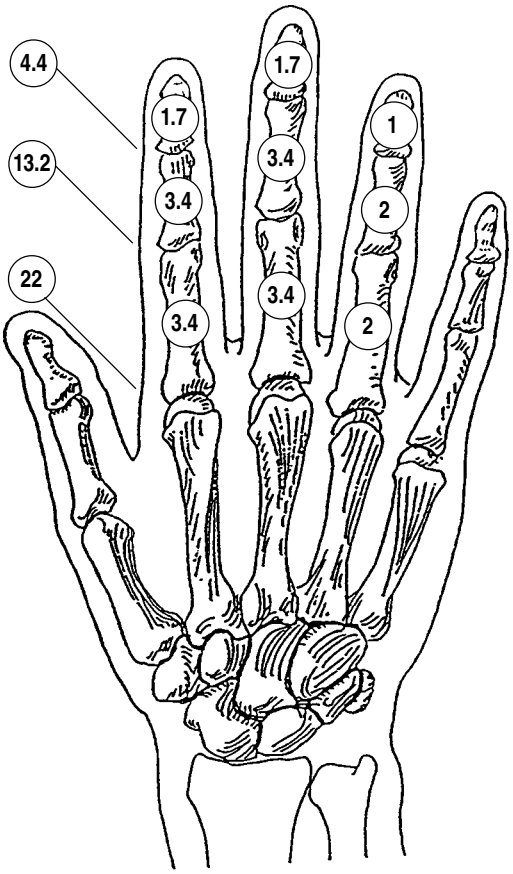


CHART 9

INDEX, MIDDLE AND LITTLE

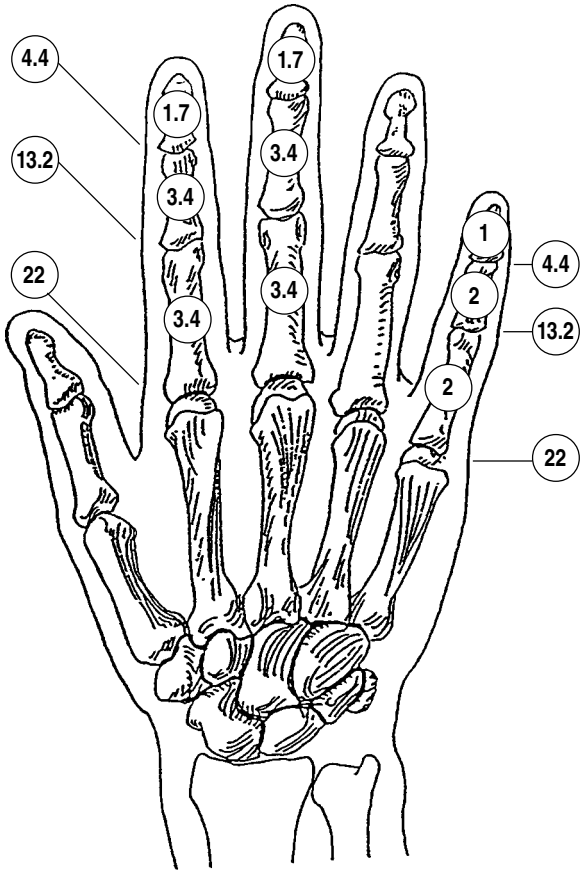


CHART 10

INDEX, RING AND LITTLE

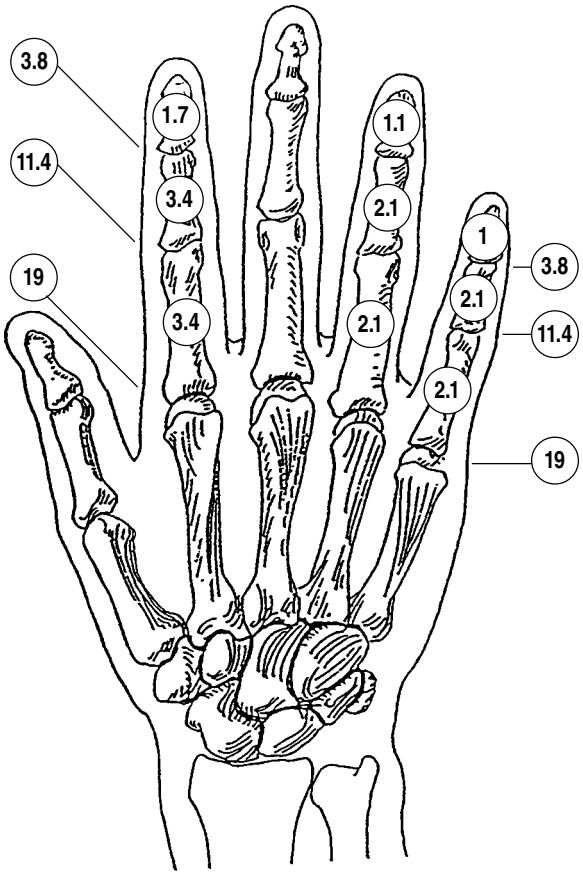


CHART 11

MIDDLE, RING AND LITTLE

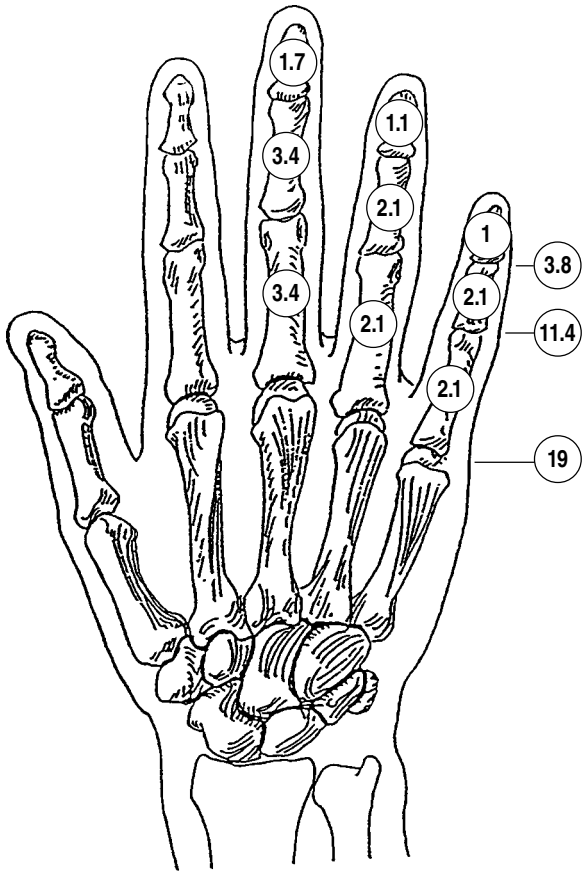
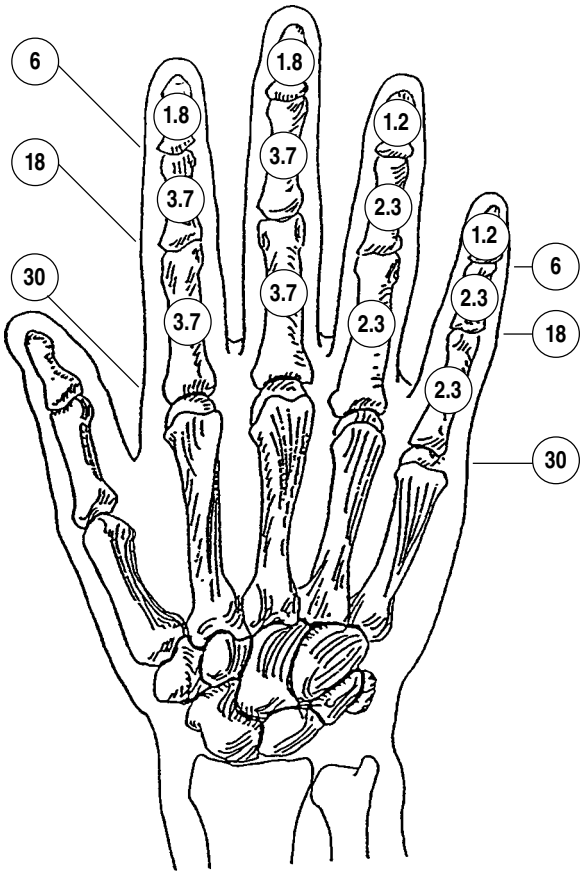


CHART 12

ALL FOUR FINGERS



APPENDIX 5

FORMULAE FOR RECALCULATING PENSIONS UNDER SECTION 24 – #42.32

A. Calculation for Workers Under 65

(a) Deemed current pension (the monthly pension being paid on the date of adjustment, plus any periodical payments that have been commuted or the life equivalent of any periodical payments made for a fixed term). See Supplement No. 8. _____ a)

(b) Monthly wage at time of injury, limited by the maximum then in effect. _____ b)

(c) Average monthly wage for B.C. during the year of injury (see B.C. Monthly Average Wage Table, Supplement No. 1). _____ c)

(d) Ratio of the monthly wage at time of injury to the B.C. average wage for that year, i.e. (b)/(c) _____ d)
(4 decimals)

(e) Estimated average monthly wage for B.C in the year of the adjustment (B.C Average Wage Table, Supplement No. 1) _____ e)

(f) Projection of pre-injury wage, limited by any maximum to the date of adjustment, i.e. including adjustment on the basis of age at date of injury (Supplement No. 9), i.e. (d) x (e) x factor. _____ f)

(g) Projected monthly earnings, limited by maximum and earnings capacity (calculated according to Supplement No. 2). _____ g)

(h) Estimated difference in earnings at time of adjustment.
(i) single injury (f) – (g)
OR
(ii) multiple claims (calculated according to Supplement No. 3). _____ h)
(if negative, enter zero)

(i) Adequate compensation = .75 x (h). _____ i)

(j) Potential adjustment to monthly pension, i.e., (i) – (a). _____ j)
(if negative, enter zero)

(k) Statutory maximum (maximum earnings applicable under Section 33 on the date of adjustment). _____ k)

(l) Maximum which would be currently payable to a worker in the pre-injury occupation of the applicant worker with a permanent disability assessed at 100%, i.e., .75 x (k). _____ l)

(m) Percentage of total disability that would be awarded at the date of the adjustment to a worker suffering the same disability as the applicant worker. _____ m)

(n) Maximum adjusted pension applicable on this claim (l) x (m). _____ n)

(o) Adjusted monthly pension = lesser of (n) or (i). _____ o)

(p) Actual adjustment. Pension increased by (o) – (a). _____ p)

The new rate of pension is the amount shown in (o).

B. Calculation for Workers 65 and Over

(a) Year of Birth. _____ a)

(b) Year of Injury. _____ b)

(c) Deemed current pension (the monthly pension being paid on the date of the adjustment, plus any periodical payments that have been commuted or the life equivalent of any periodical payments made for a fixed term. See Supplement No. 8). _____ c)

(d) Projected monthly loss of retirement income from reduced savings (calculated according to Supplement No. 4.). _____ d)

(e) Monthly reduction of post-retirement earning capacity (calculated according to Supplement No. 5). _____ e)

(f) Projected monthly income loss from other retirement sources (calculated according to Supplement No. 6). _____ f)

(g) Projected retirement income loss (d + e + f). _____ g)

(h) Adequate compensation, i.e., .75 x (g) _____ h)

(i) Potential adjustment to monthly pension, i.e., (h) – (c). _____ i)
(if negative, enter zero)

(j) Statutory maximum (maximum earnings applicable under Section 33 on the date of adjustment). _____ j)

(k) Maximum which would be currently payable to a worker in the pre-injury occupation of the applicant worker with a permanent disability assessed at 100%, i.e., .75 x (j). _____ k)

(l) Percentage of total disability that would be awarded at the date of the adjustment to a worker suffering the same disability as the applicant worker. _____ l)

(m) Maximum adjusted pension applicable on the claim, i.e., (l) x (k). _____ m)

(n) Adjusted monthly pension, i.e., lesser of (m) or (h). _____ n)

(o) Actual adjustment, pension increased by (n) – (c). _____ o)

SUPPLEMENT NO. 1

B.C. MONTHLY AVERAGE WAGE[1] TABLE

Calendar Year	Index
1997	$2,659.00
1998	2,679.00
1999	2,705.00
2000	2,755.00

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

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[1] Computed as 4.33 times the Industrial Aggregate Average Weekly Wage for British Columbia. Editions of this table distributed prior to 1986 were based on the Industrial Composite Average Weekly Wage for British Columbia. The basis for the Industrial Aggregate was changed in 1994. The average wage index for each of the years in this table has been put on the current Industrial Aggregate basis, so that ratios can be taken between indexes for any two years in the table.

SUPPLEMENT NO. 2

PROJECTED MONTHLY EARNING CAPACITY, NOT LIMITED BY MAXIMUM

(1) Actual monthly earnings from work and income from self-employment. _____ 1)

(2) Adjustment to present monthly earnings to allow for transitory circumstances and arrive at a long-term projection. _____ 2)

(3) Projected monthly earnings = 1) adjusted by 2). _____ 3)

(4) Any earnings reduction resulting from personal choice or circumstance unrelated to the compensable disability, e.g. a non-compensable disability, personal preference for an occupation less well paid than one that the worker could reasonably undertake or voluntary retirement. _____ 4)

(5) Projected monthly earnings adjusted for non-compensable loss, (3) + (4). _____ 5)

The figure in Item (5) is transferred to Item (g) on the worksheet for workers under 65.

SUPPLEMENT NO. 3

ESTIMATE OF DIFFERENCE IN EARNINGS AT TIME OF ADJUSTMENT TO EACH CLAIM IN A MULTIPLE CLAIM SITUATION

(1) Actual present monthly earnings from employment and self-employment.
under 65, calculation sheet Item (g)
OR
aged 65 or over, Supplement 4
Item (8). _____ 1)

(2) Highest projected monthly earnings of all the claims being considered.
under 65, calculation sheet Item (f)
OR
aged 65 or over, Supplement 4
Item (7). _____ 2)

(3) Earnings impairment at time of adjustment based on claim with highest projected wage, i.e. (2) – (1). _____ 3)
(if negative, enter zero)

(4) Sum of disability percentages from all claims in the multiple series. _____ 4)

(5) Percentage of disability for this claim, Claim No. ___ of ___ Multiple Claims. _____ 5)

(6) Estimate of monthly earnings loss as if this claim had been the only disability sustained, i.e. (5)/(4) x (3) _____ 6)

ITEM (6) IS TRANSFERRED TO (h) IN THE CALCULATION SHEET FOR WORKERS UNDER 65, OR TO SUPPLEMENT 4 ITEM 9, WHEN CONSIDERING WORKER AGED 65 OR OVER.

Note, if Item 3 on this supplement is zero for the first claim considered, it will be zero for all claims in the series.

SUPPLEMENT NO. 4

PROJECTED MONTHLY LOSS OF RETIREMENT INCOME FROM REDUCED SAVINGS

(1) Year in which age 65 was attained. _____ 1)

(2) Disabled work years due to compensable disability, i.e., (1) – year of injury. _____ 2)

(3) Monthly wage at time of injury, limited by the maximum then in effect. _____ 3)

(4) Average monthly wage for B.C. during the year of injury (see B.C. Monthly Average Wage Table, Supplement No. 1). _____ 4)

(5) Ratio of the monthly wage at time of injury to the B.C. average wage for that year, i.e., (3)/(4). _____ 5)
(4 decimals)

(6) Estimated average monthly wage for B.C. in the year worker attained age 65 (see B.C. Monthly Average Wage Table, Supplement No. 1). _____ 6)

(7) Projection of pre-injury wage, limited by any maximum, to the year in which age 65 was attained, including adjustment on the basis of age at date of injury, (Supplement No. 9), i.e., (5) x (6) x factor. _____ 7)

(8) Adjusted monthly earnings in year age 65 was attained, limited by a maximum (calculated according to Supplement No. 7). _____ 8)

(9) Estimated difference in earnings in year age 65 was attained:
(i) single injury, i.e. (7) – (8)
OR
(ii) multiple claims (calculated according to Supplement No. 3). _____ 9)
(if negative, enter zero)

(10) Ratio of the estimated difference in earnings to the B.C. average wage in the year age 65 was attained, i.e. (9)/(6). _____10)
(4 decimals)

(11) Estimated average monthly wage for B.C. in the year of adjustment (see Supplement No. 1). _____11)

(12) Projection of estimated monthly wage loss in the year age 65 was attained to the date of adjustment, i.e., (10) x (11). _____12)

(13) Total work months disabled due to compensable disability, i.e., 12 months/ year x (2). _____13)

(14) Lifetime lost earnings to age 65 expressed in terms of most recent dollars, i.e., (12) x (13). _____14)

(15) Deemed total disability pension payments to age 65 = deemed current pension (including term pensions expiring at age 65) x (13). _____15)

(16) Net lifetime lost income,
i.e., (14) – (15). _____ 16)

(17) Projected monthly loss of retirement income from reduced savings,
i.e., 0.0005 x (16). _____ 17)

THE FIGURE SHOWN AS ITEM (17) IS TRANSFERRED TO ITEM (d) ON THE CALCULATION SHEET FOR WORKERS 65 AND OVER.

SUPPLEMENT NO. 5

MONTHLY REDUCTION OF POST-RETIREMENT EARNING CAPACITY

(1) Percentage of total disability that would be awarded at the date of the adjustment for the disability sustained by the applicant. %_____1)

(2) Monthly allowance for loss of earning capacity from the disability.
$0.80 for each 1% of total disability,
i.e., $0.80/per 1% x (1). $_____ 2)

THIS FIGURE SHOWN AS ITEM (2) IS TRANSFERRED TO ITEM (e) ON THE CALCULATION SHEET FOR WORKERS AGED 65 AND OVER.

The cash figure in Item (2) will be adjusted with the Consumer Price Index, the first such adjustment being made on July 1, 1976.

Rates

July 1, 2000	–	$2.57 for each 1%
January 1, 2001	–	$2.62 for each 1%
July 1, 2001	–	$2.67 for each 1%
January 1, 2002	–	$2.68 for each 1%

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

SUPPLEMENT NO. 6

PROJECTED MONTHLY LOSS OF OTHER RETIREMENT INCOME

ACTUAL INCOME PER MONTH (apart from earnings)

(1)	Canada Pension benefits.	_____	1)
(2)	Pension benefits from employment (employer-operated or occupational pension plan).	_____	2)
(3)	Other government benefits (but not Mincome or similar guarantees).	_____	3)
(4)	Total actual retirement income; total of (1) through (3).	_____	4)

PROJECTED INCOME BENEFIT PER MONTH (estimated retirement income the worker would be receiving if the compensable injury had not occurred. The projected benefits are based on the assumption that if the disability had not occurred, the worker would have remained in the pre-injury occupation until the age of 65 years).

(5)	Canada Pension Plan benefits.	_____	5)
(6)	Pension benefits from employment (employer-operated or occupational pension plan).	_____	6)
(7)	Other government benefits (but not Mincome or similar guarantees).	_____	7)
(8)	Total projected retirement income, i.e., total of Items (5) through (7).	_____	8)
(9)	Retirement income loss (8) – (4).	_____	9)

THE FIGURE FOR ITEM (9) IS TRANSFERRED TO ITEM (f) ON THE WORKSHEET.

SUPPLEMENT NO. 7

ADJUSTED MONTHLY INCOME FROM EMPLOYMENT, SELF-EMPLOYMENT AND REPLACEMENT EARNINGS SOURCES IMMEDIATELY PRIOR TO AGE 65

(1) Monthly earnings immediately prior to age 65. _____ 1)

(2) Adjustment for any loss of earnings resulting from personal circumstances unrelated to the disability, i.e., a non-compensable disability that arose subsequent to the disability, or personal preference for early retirement. _____ 2)

(3) Estimated equivalent monthly income worker was receiving from a source which in nature replaced earnings income because of a non-compensable disability. _____ 3)

(4) Adjusted monthly income, i.e., (1) + (2) + (3). _____ 4)

THE FIGURE SHOWN AS ITEM (4) IS TRANSFERRED TO (8) ON SUPPLEMENT NO. 4.

SUPPLEMENT NO. 8

CALCULATION OF DEEMED CURRENT PENSION

(1) Monthly payment for either permanent partial or permanent total disability which is currently being paid to the worker. _____ 1)

(2) Value of commutation(s) in terms of $ per month as at date of commutation. _____ 2)

(3) Deemed current pension (1) + (2). _____ 3)

ITEM (3) IS TRANSFERRED TO ITEM (c) ON THE CALCULATION SHEET FOR WORKERS 65 AND OVER OR TO ITEM (a) ON THE CALCULATION SHEET FOR WORKERS UNDER 65.

SUPPLEMENT NO. 9

ADJUSTMENT OF PRE-INJURY WAGE ON THE BASIS OF AGE AT DATE OF INJURY

Age at Date of Injury	Adjustment Factor
14	2.0
15	1.7
16	1.5
17	1.3
18	1.2
19	1.2
20	1.1
21	1.1
22	1.1
23 or over	1.0

APPENDIX 6

MAXIMUM FINES FOR COMMITTING OFFENCES UNDER THE *ACT*

Part 1 – Offences for which No Other Punishment is Provided – #47.20, #74.10, #94.15, #95.30, #98.12, #99.00

Section 77(2) provides that "Every person who commits an offence under this Act for which no other punishment has been provided is liable on conviction to a fine not exceeding . . ." the amount set out below.

Date			Amount
July 1, 2000	–	December 31, 2000	$3,905.51
January 1, 2001	–	June 30, 2001	3,981.95
July 1, 2001	–	December 31, 2001	4,044.49
January 1, 2002	–	June 30, 2002	4,058.39

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

Part 2 – Maximum Fine for Discouraging Worker from Reporting to Board – Section 13(2) – #94.20

Date			Employer	Supervisor
January 1, 1998	–	June 30, 1998	$18,745.52	$3,749.15
July 1, 1998	–	December 31, 1998	18,815.01	3,763.05
January 1, 1999	–	June 30, 1999	18,936.62	3,787.37
July 1, 1999	–	December 31, 1999	19,127.72	3,825.59

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

Part 3 – Maximum Fine for Obstructing Board in Investigation – Section 71(8) – #98.11

Date			Maximum Amount
July 1, 1998	–	December 31, 1998	$18,815.01
January 1, 1999	–	June 30, 1999	18,936.62
July 1, 1999	–	December 31, 1999	19,127.72

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

APPENDIX 7

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REHABILITATION SERVICES AND CLAIMS MANUAL REFERENCE INDEX

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YOUTH AS A CRITERIA FOR RATE SETTING	ACT 33(3), 67.10
YUKON TERRITORY – FEDERAL GOVERNMENT EMPLOYEES	24.00