March 2003 Update 2003 – 2

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

This update of the *Rehabilitation Services and Claims Manual* contains amendments to the *Manual* approved by the Board of Directors since update 2003 – 1.

The update consists of policy amendments arising from the *Workers Compensation Amendment Act (No. 2), 2002* ("Bill 63"), which amended the *Workers Compensation Act* effective March 3, 2003. The policy amendments include the following:

- amendments relating to the Board's authority to change its previous decisions;
- amendments relating to the Board's obligation in decision-making to apply a policy of the Board of Directors that is applicable to the case before it; and
- various consequential amendments to further implement Bill 63 and the policy amendments noted above.

A list of amendments has been included as part of the package.

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

DOUGLAS ENNS
Chair, Board of Directors

Attachments

SUMMARY OF AMENDMENTS – Volume II – Update 2003 – 2

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Amendments relating to the Board's authority to change its previous decisions and orders, as follows:

- the deletion of Chapter 14, Reopenings and Reconsiderations; and
- replacement by the POLICY statements in Items C14-101.01 to C14-105.01.

Amendments relating to the obligation of the Board in decision-making to apply a policy of the Board of Directors that is applicable to the case before it, as follows:

- new policy item #2.20, Application of the *Act* and Policies.

Various consequential amendments, as follows:

- the deletion of Chapter 13 and its replacement by the POLICY statements in Items C13-100.00 – C13-104.00, including the policy items in the Appendix to Item C13-103.00 and the policy items in the Appendix to Item C13-104.00, insofar as the Appendices are consistent with the *Workers Compensation Amendment Act (No. 2), 2002*; and
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#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

NOTES

(1) Chapter 2

(2) Chapter 8

(3) Chapter 3

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(5) Chapters 3 and 4

(6) Chapter 3

(7) Chapter 5

(8) Chapter 6

(9) Chapter 8

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(11) Chapter 11

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(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**

Immediately following acceptance of the claim, if the worker is still off work, the file will be discussed with a Board Medical Advisor, who should examine the worker 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 worker 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.

#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.

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.

#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 worker is still recovering from a previous work injury, the principles set out in policy item #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.

EFFECTIVE DATE: March 3, 2003 (as to references to the Review Division and the Workers' Compensation Appeal Tribunal and deletion of references to the Board's Rehabilitation Residence)

APPLICATION: Not applicable.

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 Board officer concludes that the facts do not warrant recognition of the worker’s condition as an occupational disease, the Board officer will disallow the claim without referring it to the panel, and will notify the worker and employer. This is a reviewable decision. The Board officer shall provide the Manager with a memorandum advising that the worker’s condition is not one previously designated or recognized by the Board as an occupational disease, the nature of the condition, and the Board officer’s decision to disallow the claim.

The Manager, upon receipt of a recommendation from the Board officer for recognition of the worker’s condition as an occupational disease, and after considering and discussing the claim 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. 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 Board officer 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(4.2), where a particular process, trade or occupation is specified, or by regulation of general application, 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: March 3, 2003 (as to references to review)
APPLICATION: Not applicable.

#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 policy item #113.10).

#26.20 Establishing Work Causation

The fundamental requirement for a disease to be compensable under section 6(1) of the *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

For this purpose the Board officer will conduct a detailed investigation of the worker's circumstances including information about the worker, their diagnosed condition, and their workplace activities. The Board officer is seeking to gather evidence that tends to establish that there is a causative connection between the work and the disease. The Board officer 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 Board officer 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 Board officer 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 Board officer, to be sufficiently complete the Board officer should obtain evidence from both the worker and the employer, particularly if the Board officer 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 policy item #83.13).

#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 acceptance of the claim. 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 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.

Workers who develop non-traumatic noise induced hearing loss are, subject to the time periods referred to in section 23.1 of the *Act*, assessed for a permanent disability award under section 23 of the *Act*.

Hearing loss permanent disability awards 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.

Section 7(4.1) also provides:

> Compensation paid for a worker's loss of hearing under subsection (4) must not be less than the amount determined 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 functional 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 may trigger consideration by the Board of a permanent disability assessment 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 section 23(1) method of permanent disability assessment. 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.

The duration of entitlement to permanent disability periodic payments is established under section 23.1 of the *Act* and discussed in policy item #41.00, Duration of Permanent Disability Periodic Payments.

#31.60 Reopenings of Section 7 Pension Decisions

Where the loss of hearing of a worker who is in receipt of a permanent disability award under section 7 is retested on or after June 30, 2002 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 permanent disability award decision is reopened and the 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 award is reopened. Where this occurs, two further considerations would apply.

    (a) Where the worker has been paid the award 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 award 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 permanent disability award was set, but the improvement is within a range up to and including 10 decibels, the permanent disability award is not reopened.

A worker who has ceased to have entitlement to a permanent disability award in accordance with the provisions of section 23.1 of the *Act* (see policy item #41.00) will not be retested by the Board.

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 *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

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 can 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;

cases, an arrangement is normally made with Human Resources Development Canada 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, Human Resources Development Canada will "top up" 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 up" by Human Resources Development Canada 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.

EFFECTIVE DATE: November 1, 2002
APPLICATION: To decisions made on or after November 1, 2002 on claims adjudicated under the *Act*, as amended by the *Workers Compensation Amendment Act, 2002.*

#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 are paid for as long as a worker continues to be disabled because of the injury or until the worker has attained the age at which compensation is terminated under section 23.1 of the *Act*. 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 worker has reached a point of recovery at which he or she is very close to returning to work. The worker may have a psychological impairment that persuades the Board to continue a convalescent period to enable the worker to adapt. But a judgment might rationally be made that the worker 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 worker 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 the 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 Board officer will then decide whether or not the worker's condition is permanent to the extent that a permanent disability award should be assessed.

In the case of (a), the condition is considered permanent and the permanent disability award 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 worker 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 permanent disability award 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 permanent disability award 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 worker'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 Board officer 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 permanent disability award 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 permanent disability award 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 worker might be looking for employment in the meantime.

EFFECTIVE DATE: March 3, 2003 (as to deletion of reference to the Review Division)
APPLICATION: Not applicable.

For the purposes of determining whether the worker meets the test set out under section 23(3) and (3.1), the Board must consider the combined effect of a worker's occupation at the time of injury and the resulting disability. While a worker may experience a loss of earnings as a result of a work injury, that fact alone is not sufficient to meet the test set out under section 23(3) and (3.1).

The following is a list of criteria that must be considered under section 23(3) and (3.1). Each of these criteria must be satisfied in order for a worker to be assessed under section 23(3).

- The occupation at the time of injury requires specific skills which are essential to that occupation or to an occupation of a similar type or nature;

- As a result of the compensable disability, the worker is no longer able to perform the essential skills needed to continue in the occupation at the time of injury or in an occupation of a similar type or nature;

- The effect of the compensable disability is that the worker is unable to work in his or her occupation or in an occupation of a similar type or nature, or to adapt to another suitable occupation, without incurring a significant loss of earnings.

Skills are defined in this context as the learned application of knowledge and abilities.

In all cases, the Board must determine if, following recovery from a work injury, a worker is either able to return to the occupation at the time of injury or to adapt to another suitable occupation. This determination includes consideration of both the worker's transferable skills and the worker's post-injury functional abilities. In the vast majority of cases a worker's entitlement to a permanent partial disability award is determined under the section 23(1) method and this estimate of impairment of earning capacity is considered to be appropriate compensation.

However, in exceptional cases, the amount determined under section 23(1) may not appropriately compensate a worker. In these cases, medical evidence confirms that the work injury makes it impossible for a worker to continue in the occupation at the time of injury or in an occupation of a similar type or nature. In addition, the worker is considered unable to adapt to another suitable occupation without incurring a significant loss of earnings due to the work injury.

For the purposes of this policy, a significant loss of earnings means the Board may conclude in these exceptional cases, that the loss of earnings a worker will experience as a result of the combined effect could not have been anticipated under the section 23(1) method of estimating a worker's long term loss of earning capacity.

An example of when the combined effect may be considered so exceptional is one where a work injury results in a significant disability of two digits on the dominant hand of a worker whose occupation requires fine motor skills. As a result of the disability, the worker is no longer able to perform fine motor skills, and consequently, is unable to continue in the pre-injury occupation, or another occupation of a similar type or nature. In addition, due to the disability, the worker is unable to adapt to another suitable occupation without incurring a significant loss of earnings.

As a result, the section 23(1) award may not be considered to appropriately compensate the worker for the impact of the combined effect, and may therefore result in a consideration under section 23(3).

#40.01 Decision-Making Procedure under the Section 23(3) Method

Section 23(3) assessments are undertaken if a permanent partial disability results from a worker's injury, and the Board makes a determination under subsection (3.1) with respect to the worker.

The Disability Awards Committee is ultimately responsible for the conclusion on permanent partial disability awards assessed under section 23(3) of the *Act*. The Board officer in Disability Awards is required to conduct the necessary investigations and make a specific recommendation to the committee regarding a worker's eligibility for a section 23(3) assessment and, in cases where an assessment is undertaken, the worker's entitlement to an award.

It is the function of the Committee, following any further investigation it considers necessary, to agree or disagree with the Board officer's recommendation. If the Committee agrees, the Board officer will implement the initial recommendation. If the Committee disagrees with the Board officer's recommendation, it will either implement its findings 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.

The rules of evidence followed by Board officers in Disability Awards and the Disability Awards Committee are discussed in policy item #97.40.

A review by the Review Division may be requested from a decision made by a Board officer in Disability Awards or the Disability Awards Committee.

EFFECTIVE DATE: March 3, 2003 (as to reference to review)
APPLICATION: Not applicable.

#40.14 Provision of Employability Assessments

Workers are provided with a copy of a completed employability assessment before a decision is made on entitlement to a section 23(3) award. 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 section 23(3) award are known and agreed to, the 30-day waiting period may be waived.

#40.32 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 permanent disability award would be subject to termination or downward adjustment.

#41.00 DURATION OF PERMANENT DISABILITY PERIODIC PAYMENTS

Section 23.1 of the *Act* provides:

Compensation payable under section 22(1), 23(1) or (3), 29(1) or 30(1) may be paid to a worker, only

(a) if the worker is less than 63 years of age on the date of the injury, until the later of the following:

  (i) the date the worker reaches 65 years of age;

  (ii) if the Board is satisfied the worker would retire after reaching 65 years of age, the date the worker would retire, as determined by the Board, and

(b) if the worker is 63 years of age or older on the date of injury, until the later of the following:

  (i) 2 years after the date of injury;

  (ii) if the Board is satisfied that the worker would retire after the date referred to in subparagraph (i), the date the worker would retire, as determined by the Board.

Section 23.1 of the *Act* recognizes age 65 as the standard retirement age for workers. Confirmation of age 65 as the standard retirement age may also be found in the contractual terms of some employer sponsored pension plans and collective agreements. As well, Statistics Canada information lends weight to the general view that, on average, workers retire at or before 65 years of age. (9)

Section 23.1 also permits the Board to continue to pay benefits where the Board is satisfied that the worker would retire after the age of 65 if the worker had not been injured.

The standard of proof under the *Act* is on a balance of probabilities as described in policy item #97.00, Evidence. However, as age 65 is considered to be the standard retirement age, the Board requires evidence that is verified by an independent source to confirm the worker's subjective statement regarding his or her intent to work past age 65. Evidence is also required so that a Board officer can establish the worker's new retirement date for the purposes of concluding permanent disability award payments. If the worker's statement is not independently verifiable, the Board officer will make a determination based on the evidence available, including information provided by the worker.

Examples of the kinds of independent verifiable evidence that may support a worker's statement that he or she intended to work past age 65, and to establish the date of retirement, include the following:

- names of the employer or employers the worker intended to work for after age 65, a description of the type of employment the worker was going to perform, and the expected duration of employment
- information from the identified employer or employers to confirm that he or she intended to employ the worker after the worker reached age 65 and that employment was available
- information provided from the worker's pre-injury employer, union or professional association to confirm the normal retirement age for workers in the same pre-injury occupation
- information from the pre-injury employer about whether the worker was covered under a pension plan provided by the employer, and the terms of that plan

This is not a conclusive list of the types of evidence that may be considered. A Board officer will consider any other relevant information in determining whether a worker would have worked past age 65 and at what date the worker would have retired.

Where the Board is satisfied that a worker would have continued to work past age 65 if the injury had not occurred, permanent disability award periodic payments may continue past that age until the date a Board officer has

established as the worker's retirement date. At the worker's age of retirement, as determined by a Board officer, periodic payments will conclude even if the worker's permanent disability remains.

In situations where a worker in receipt of a permanent disability periodic payments dies from causes unrelated to the disability, the periodic payments will continue for the full month in which the death occurred. The effect of this policy will be that no overpayments will be considered to have arisen for the period from the date of the worker's death up to the end of the month covered by the last periodic payment.

If the worker dies prior to the implementation of the permanent disability award, 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 policy item #45.00.

42.00 PAYMENT OF PERMANENT DISABILITY AWARDS

Permanent disability awards under sections 22 and 23 are normally payable monthly until the worker reaches retirement age as determined by the Board. However, some are paid as lump sums. The cheques are mailed to the worker'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.

#42.10 Commencement of Periodic Payments

The general rule is that the permanent disability periodic payments commence at the date when the worker'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 permanent disability periodic payments 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 90% of the worker's average net earnings in this employment. Should the worker eventually be assessed at a permanent disability award 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 permanent disability award 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 Board 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 award. 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 permanent disability periodic payments. 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 periodic payments.

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 Board officer in Disability Awards, the permanent disability award will be backdated to the date benefits were terminated under section 30.

#42.11 Commencement Following Medical Review Panel Certificate

Where a permanent disability award 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 permanent disability award 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.

#42.12 Retroactive Awards

Where a permanent disability award is granted 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 award when the worker received wage-loss or rehabilitation benefits. However, no such reduction is made when

the award is granted 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 policy item #50.00.

#42.20 Permanent Disability Award Adjustments

If a permanent disability award 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 permanent disability award 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.

#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 policy item #45.00), the award for the permanent disability is a periodic payment, 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% 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 policy item #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.	Mild alteration of texture.	Moderate thickening.	Major thickening.	Severe
keloid scarring hardening.	Slight wrinkly, furrows or marks.	Moderate hardening. Mild dryness or scaling. Prone to pimples.	Major hardening. Moderate dryness or scaling. Frequent pimples Prone to ulceration.	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.	Severe 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, 2003 – December 31, 2003

	Minimum	**Maximum**
Head and Neck		
1.	$ 0	$ 4,804.32
2.	4,804.32	9,608.62
3.	9,608.62	29,186.14
4.	29,186.14	48,643.59
Each Hand		
1.	$ 0	$ 1,561.40
2.	1,561.40	3,242.91
3.	3,242.91	9,608.62
4.	9,608.62	16,214.52
Each Arm		
1.	$ 0	$ 1,201.06
2.	1,201.06	2,402.15
3.	2,402.15	7,326.55
4.	7,326.55	12,130.88
Each Leg (including the foot)		
1.	$ 0	$ 840.74
2.	840.74	1,561.40
3.	1,561.40	4,804.32
4.	4,804.32	8,047.21

Torso		
1.	$ 0	$ 840.74
2.	840.74	1,561.40
3.	1,561.40	4,804.32
4.	4,804.32	8,047.21

The above figures are adjusted on January 1 of each year. Effective June 30, 2002, the percentage change in the consumer price index determined under section 25.2 of the *Act*, as described in policy item #51.20 will be used.

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 was 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 was 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) of the *Act* provides:

> 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 worker 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.

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 worker 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 worker 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 worker's "disability" as may reasonably be attributable to the personal injury or disease. "Disability" 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. (10)

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 net 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 permanent disability award granted under section 23(1) is 90% of 10% of $1,000, i.e. $90.00 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 90% of 7% of $1,000 per month, i.e. $63.00.

#44.31 Application of Proportionate Entitlement

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 award is made under section 5(5). If it decides that a portion of the loss is attributable to the pre-existing disability, a permanent disability award is only granted for the portion attributable to the compensable disability.

The Board feels that this is fair to workers 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).

#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 future amounts that are to be set aside for payment of a retirement benefit and 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. (11)

#45.10 Permanent Disability Periodic Payment 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 permanent disability periodic payment is not more than $200.00 per month,

a lump sum will be awarded in lieu of a monthly permanent disability periodic payment and the additional future amounts to be set aside by the Board for the payment of a retirement benefit under section 23.2 of the *Act*.

Category B:

In any case not within Category A, where the permanent disability periodic payment is more than $200.00 per month, the award will consist of a monthly permanent disability periodic payment and the additional future amounts to be set aside by the Board for the payment of a retirement benefit. A commutation will only be considered under the circumstances outlined below.

With the exception of the retirement benefit provision, this policy applies similarly to periodic payments of compensation made to a dependant of a deceased worker.

Where a worker or dependant has more than one permanent disability award 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 granting of a permanent disability award 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.

#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 award.

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 an award 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 permanent disability award when the improvement occurs. The possibility of such an improvement may, however, be taken into account if it is significant. It may influence the term and 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.

#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. The letter of decision sent by the Disability Awards Officer was therefore void, and no payment was due under it.

#45.30 Types of Commutations Permitted

Where a total or partial commutation of a permanent disability award is granted, the corresponding portion of the future amounts that are to be set aside for payment of a retirement benefit will also be commuted.

For partial commutations, any remaining future amounts to be set aside on the future reduced permanent disability periodic payments, will continue to be set aside by the Board for payment to the worker on reaching retirement age.

Any amounts that have already been set aside by the Board in the retirement reserve will be held in the reserve until the worker reaches retirement age. These amounts will not be commuted. Please refer to Chapter 18, Retirement Benefits, for further information regarding the provision of this benefit.

There are basically four types of commutations that the Board may permit:

1. A partial commutation by way of a term of years resulting in a total suspension of both the permanent disability periodic payments and the corresponding additional future amounts to be set aside by the Board for the payment of a retirement benefit for a fixed period. After which, the permanent disability periodic payments, and the additional future amounts to be set aside by the Board, resume with full payments.

2. A partial commutation by way of a reduced level of permanent disability periodic payments and a reduced level of the corresponding additional future amounts set aside by the Board for the payment of a retirement benefit for a term of years. After which, the full periodic payments as well as the amounts to be set aside by the Board resume.

3. A partial commutation resulting in a reduced level of permanent disability periodic payments and the corresponding additional future amounts set aside by the Board for the payment of a retirement benefit, until the worker reaches 65 years of age.

4. A total commutation of the whole permanent disability award and the additional future amounts set aside by the Board for the payment of a retirement benefit.

With the exception of the retirement benefit provisions, the Board permits the same types of commutations of periodic payments of compensation made to a dependant of a deceased worker.

A commutation for a term of years will be made only for units of whole years.

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.

#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 workers in receipt of permanent disability awards 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 permanent disability periodic 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 permanent disability periodic payments. It may, in such cases, be more appropriate to refer the worker for financial counselling rather than to attempt to resolve the situation by a commutation of permanent disability periodic 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 workers 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 permanent disability award reserve and a retirement reserve are established or a liability is calculated for an award and a retirement benefit, the monthly payment amount and the periodic future amounts to be set aside by the

Board for the payment of a retirement benefit, are converted to a lump sum by applying an actuarial net discount rate. This provision also applies where a reserve is established or a liability is calculated for periodic payments of compensation made to a dependant of a deceased worker. The 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 permanent disability award commutation is granted, the monthly permanent disability award amount and the periodic amounts set aside by the Board for a retirement benefit are converted to a lump sum by applying a commutation net discount rate. For permanent disability awards and the future amounts to be set aside by the Board for the payment of a retirement benefit 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 permanent disability awards and the future amounts to be set aside by the Board for the payment of a retirement benefit that are commuted by the Board at the worker's request, the commutation net discount rate used will be equal to the actuarial net discount rate increased by .5 percentage points. The increased net discount rate also applies to a commutation granted by the Board at the surviving dependant's request.

#46.00 REVIEW OF OLD PENSIONS UNDER SECTION 24

Section 24(2) of the *Act* provides:

> 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.

#46.01 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 *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 section 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. (12)

#46.02 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. (13)

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. (14)

The calculation of benefits is made in the manner the Board determines. (15)

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 BC (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 cost of listing adjustment as described in policy item #51.00, will be regarded as the permanent disability award 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 cost of living adjustments as described in policy item #51.00 or the adjusted permanent disability award 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.

#46.03 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. (16)

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. (17)

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. (18)

#46.04 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. (19)

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

#46.05 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. (20)

#46.10 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."

#46.11 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 policy item #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 $\frac{I}{H} \times F$ $\frac{2.00}{56.00} \times 50.40$	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.

#46.12 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.

#46.13 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. (21) The worker must also wait for 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.

#46.14 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). (22)

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 permanent disability award per month (23)
   $\frac{18.58}{100}$ (A) x $\frac{62\text{-}1/2}{100}$ x 80.00 (B) $9.29

   D. Monthly permanent disability award that would have been payable if there had been no term award under provision in policy item #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 permanent disability award less than under policy item #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
$\frac{40.97}{100}$ (A) x $\frac{66\text{-}2/3}{100}$ x 150.00 (B) $40.97

D. Monthly amount commuted $14.95

E. Percentage of total disability commuted
$\frac{14.95}{40.97}$ (D) x 40.97 (A) 14.95%

F. Provision in policy item #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 policy item #39.62
$\frac{14.95}{100}$ (E) x 130.00 $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

#46.15 Cost of Living Adjustment After Reinstatement

Cost of living adjustments after the establishment of the new periodical payments are based on the sum of the amounts calculated under clauses (a) and (b) in policy item #46.14. (24) 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 award is still subsisting, the residue of the original award may be blended with the reinstated award under section 26. Where the commutation was total, the formula applies to the reinstated award, and where the commutation was partial, it applies to the blend of the residue of the original award with the reinstated award.

The formula is:

1.	The amount of pension benefits being paid for the month preceding the cost of living adjustment	$
	PLUS	
2.	The monthly amount of pension that had been commuted	$
	Subtotal	$
3.	The application of the indexing factor described in policy item #51.00 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 cost of living adjustment.

#46.16 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.

NOTES

(1) See policy item #65.04

(2) See policy item #40.00

(3) S.23(2)

(4) Permanent Disability Evaluation Schedule Appendix 4

(5) See policy item #25.10

(6) S.23(4); See policy item #34.20

(7) See policy item #37.21

(8) S.33(4)

(9) Earnings and Employment Trends, Jan/Feb 2001, BC Stats, Ministry of Finance and Corporate Relations, Province of British Columbia

(10) S.5(5)

(11) S.35(3)

(12) S.24(7)

(13) S.24(3)

(14) S.24(5)

(15) S.24(6)

(16) S.24(8)

(17) S.24(9)

(18) S.24(12)

(19) S.24(11)

(20) S.24(10)

(21) S.26(2)

(22) S.26(4)

(23) 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%

(24) S.26(4)

#48.20 Money Owing in Respect of Benefits Paid by Other Agencies

A worker may receive benefits from other governmental or non-governmental agencies while awaiting the adjudication or a review or appeal of his or her compensation claim. If the worker eventually receives compensation benefits for the same period, the agency may have a claim against the worker for reimbursement of the funds advanced by it, but can only claim reimbursement from the Board if it is a Provincial Government agency or a municipality. 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: March 3, 2003 (as to reference to review)
APPLICATION: Not applicable.

#48.21 Employment Insurance

The essence of the arrangement between the Human Resources Development Canada 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 Human Resources Development Canada; but that is a matter between the worker and the Commission. There is no provision under the *Workers Compensation Act* for the obligation to be enforced by the Board, or for compensation benefits to be withheld because of the receipt of Employment Insurance benefits.

#48.22 Social Assistance Payments

Deductions from compensation may be made in respect of social assistance payments made to the worker by the Ministry of Human Resources or by city or municipal Social Welfare Departments.

At one time, social assistance was provided by individual municipalities, but it is now provided exclusively by the Provincial Ministry of Human Resources. The practice is that when a person who may be entitled to compensation is awarded

social 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 worker's compensation benefits the amount owed to the Ministry.

The rules set out below are followed in respect of assignments of compensation made by a worker to the Ministry of Human Resources.

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 worker 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 Permanent Disability Award Payments

   The Ministry will be refunded up to the monthly value of the permanent disability award payment 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) Permanent Disability Awards: Cash Awards or Commutations

   Where a cash award or commutation is granted, the Ministry will be reimbursed the equivalent amount of the monthly permanent disability award value of the commutation or lump sum payment that would otherwise have been payable to the worker. 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 *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 worker is advised when social assistance payments are being deducted from workers' compensation benefits.

#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 cost of living 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 worker 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 policy item #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 computer, 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.

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: March 3, 2003 (as to deletion of cross-references to payments to children on fatal claims, interim adjudications and appeals)

APPLICATION: Not applicable.

#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 Compensation Services Departments will conduct the initial collection procedure which will include the Board officer making personal contact with the worker 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 worker 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 worker 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 permanent disability lump-sum 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 Permanent Disability Awards

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 permanent disability award adjustment as follows:

(a) non-payment of the full permanent disability award for a fixed term;
(b) a partial reduction of the permanent disability award for a fixed term;
(c) a partial reduction of the permanent disability award for the duration of a worker's entitlement to a permanent disability award.

In the case of a large overpayment and/or a small award, it is also possible that the capitalization of the full award may be required to offset the overpayment.

Where a previous permanent disability 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 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 permanent disability award.

Where an award has been suspended for the purpose of paying off an amount owing to the Board, the worker will, every six months, be sent a statement showing the results of any changes in the permanent disability award amount because of cost of living adjustments, the amounts credited to the worker's account as a result of the suspension, and the amount still owing.

Permanent disability awards are made to workers and pensions are paid to dependants at 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 Vocational Rehabilitation Payments

An overpayment may be recovered from a vocational rehabilitation assistance payment at the discretion of the Board officer in Vocational Rehabilitation Services Department in consultation with the Board officer in Compensation Services Department. Every attempt is, however, made by the Board to have the worker make arrangements to repay the overpayment in some other method

rather than reduce a vocational rehabilitation payment. Recovery from a vocational rehabilitation payment would only occur under exceptional circumstances.

#48.46 Review and Appeals on Overpayments

A request for a review by the Review Division may be made on the question of whether the worker 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 policy item #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, Rehabilitation and 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

incarceration. These payments 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 payment of the worker, the worker's wife, husband or children. If not redirected, these payments 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 item #55.62 and policy item #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*) or a permanent disability lump-sum payment (provided under sections 22 and 23 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 3, 2003 (as to reference to section 258)
APPLICATION: Not applicable.

#51.00 COST OF LIVING ADJUSTMENTS TO PERIODIC PAYMENTS MADE TO A WORKER

Sections 25(1) and (2) of the *Act* provide the method for indexing periodic payments of compensation to a worker. The sections provide:

> (1) For the purposes of this section, the Board must, as of January 1 of each year,
>
> (a) determine the percentage change in the consumer price index for Canada, for all items, for the 12 month period ending on October 31 of the previous year, as published by Statistics Canada, and
>
> (b) subtract 1% from the percentage change determined under paragraph (a).
>
> (2) The percentage resulting from calculations made under subsection (1) must not be greater than 4% or less than 0%.

The Board determines the indexing factor to be applied to periodic payments of compensation to a worker in the following manner:

- The Board compares 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.
- One percentage point is subtracted from the percentage change between these two consumer price indexes.
- If the percentage that results from this subtraction is greater than 4%, it is reduced to 4%. If the percentage that results from this subtraction is less than 0%, no adjustment to periodic payments of compensation is made.

The resulting percentage changes determined annually are set out below:

Date	Percentage
January 1, 2003	2.167808

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

The resulting percentage change is applied on January 1 of each year to periodic payments of compensation made continuously in respect of an injury occurring more than 12 months before the date of the adjustment.

If the Board starts or restarts periodic payments of compensation to a worker on a date more than 12 months after the date of the worker's injury, the Board adjusts all periodic payments as if payments were made continuously from the date of injury. This means that if payments on a claim are started or restarted more than 12 months after the injury, the worker will receive the benefit of any cost of living adjustments occurring in the intermediary period as if he or she had been continuously paid since the date of injury.

Compensation paid to a worker on or after June 30, 2002 will be indexed according to section 25 of the *Act*, irrespective of the date the worker was injured. However, if the Board pays to a worker, who was injured before June 30, 2002, compensation as a result of a retroactive adjustment, the indexing rules in section 25 of the *Act*, as it read immediately before June 30, 2002, apply to the compensation benefits that should have been paid to the worker before June 30, 2002. Compensation due to the worker on or after June 30, 2002 will be indexed according to section 25 of the *Act*.

Authority to approve adjustments under section 25 has been assigned to the President.

#51.10 Cost Of Living Adjustments To Periodic Payments Made To Dependants

Sections 25.1(1) and 25.1(2) of the *Act* provide the rules for indexing periodic payments of compensation made under sections 17, 18 or 19 to dependants in respect of a death of a worker. The sections provide:

(1) For the purposes of this section, the Board must

(a) as of January 1 of each year, determine the percentage change in the consumer price index for Canada, for all items, for the 6 month period ending on October 31 of the previous year, as published by Statistics Canada, and

(b) as of July 1 of each year, determine the percentage change in the consumer price index for Canada, for all items, for the 6 month period ending on April 30 of that year, as published by Statistics Canada.

(2) The percentage resulting from calculations made under subsection (1) must not be less than 0%.

#65.02 Worker 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, date of injury earnings 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. (1)

Where a worker is engaged in two jobs, one of which is a job for which personal optional protection has been purchased, the income earned in the non-personal optional protection job will be combined with the amount of personal optional protection purchased for the other job, up to the statutory maximum, in order to determine average earnings.

#65.03 Fishers

The date of injury earnings for fishers whose remuneration is based on a share of the catch, the value of which may only be determined at a future date, will be based on the earnings over the 3-month period immediately preceding the date of injury. Where earnings information is not available for that three-month period, the worker's average earnings may be based on the 12-month period immediately preceding the worker's date of injury. See also policy item #68.63 for information on a fisher's composition of average earnings where the fisher is self-employed and owns a vessel.

#65.04 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. See policy item #93.26 regarding a worker's obligation to provide information. (2) 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.

#66.00 GENERAL RULE FOR DETERMINING LONG-TERM AVERAGE EARNINGS

Section 33.1(2) of the *Act* provides:

> Subject to sections 33.2 to 33.7, if a worker's disability continues after the end of the period referred to in subsection (1) (a) and (b) that is shorter for the worker, the Board must, for the period starting after the end of that shorter period, determine the amount of average earnings of the worker based on the worker's gross earnings, as determined by the Board, for the 12 month period immediately preceding the date of the injury.

After a claim has lasted five weeks, the Board officer considers whether it is likely to last for ten weeks and, if the Board officer has not done so already, sets in motion any enquiries necessary for a possible 10-week average earnings review.

As part of the Board officer's enquiries, information will be obtained as to the worker's earnings for the 12-month period immediately preceding the date of injury. Information will also be obtained about the worker's tax status for the previous year.

If not supplied by the employer, earnings and tax status information for the required period of time prior to the injury must be provided by the worker. The information provided must be verified information from an independent source such as wage stubs, T-4's, or letters from the Income Tax Authorities or employers.

If, at the earlier of: the day after 10 cumulative weeks of benefits have been paid to the worker; or the effective date of a permanent disability award there is insufficient information on which to complete the 10-week rate review, a provisional rate may be set until sufficient information is received. (3)

In situations where a worker is being maintained on full salary by the employer, the Board officer 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.

No refunds are made to the employer when workers covered under the *Government Employees Compensation Act* are maintained on full salary, no 10-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 ten weeks of disability and a worker is still disabled, a 10-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.

#67.00 EXCEPTIONS TO THE GENERAL RULES FOR DETERMINING AVERAGE EARNINGS

The *Act* provides a number of exceptions to the general rules in setting a worker's short-term and long-term average earnings. The Board's policies with respect to each of these exceptions are presented below. If a worker's circumstances do not fit within any of the exceptions, the applicable general rule for determining a worker's average earnings applies.

Section 33.1(3), the *Act* provides that if two or more exceptions to the general rules for determining average earnings apply to a worker, the Board must determine and apply the section that best reflects the worker's circumstances. In making this determination, "best" does not mean the highest rate possible, but rather, the rate that most closely reflects the actual loss incurred. This situation could arise if, for example, a worker was an apprentice (section 33.2) who had been employed less than 12 months (section 33.3). In this situation, the Board

would apply the section that most accurately reflects the worker's average earnings and earning capacity at the time of injury.

#67.10 Casual Workers

Section 33.5 of the *Act* provides:

> If a worker's pattern of employment at the time of the injury is casual in nature, the Board's determination of the amount of average earnings under section 33.1 from the date of the injury must be based on the worker's gross earnings, as determined by the Board, for the 12 month period immediately preceding the date of injury.

This is an exception to both general rules for determining a worker's average earnings. For a casual worker, the Board officer must use the worker's gross earnings for the 12-month period immediately before the date of the injury to establish the worker's average earnings. There is no 10-week average earnings review. Thus, the worker's average earnings determined at the outset of the casual worker's claim are also the worker's long-term average earnings.

A casual worker is a worker who has a short-term/sporadic attachment to employment. Generally the employment lasts less than three consecutive months. A worker who works "on call" for one or more employers may also be a casual worker.

Longshore workers 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 worker rather than a casual worker. Where a job is to last more than three months, the worker is generally regarded as a regular worker rather than a casual worker. Regulation 3 of the *Fishing Industry Regulations* addresses the calculation of earnings for compensation benefits.

#67.20 Personal Optional Protection

Section 33.6 of the *Act* provides:

> If an independent operator or employer, to whom the Board directs that this Part applies under section 2(2), has purchased coverage under this *Act*, the Board must determine the amount of average earnings under section 33.1 from the date of injury based on the gross earnings for which coverage is purchased.

#70.20 Reopenings Over Three Years

Section 32 of the *Act* provides:

> (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 three 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 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 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.

In applying this policy, where the original wage rate was set before June 30, 2002, the wage rate must be reset in order to convert it from a rate based on 75% of gross average earnings to a rate based on 90% of average net earnings. This conversion will involve using information from the time of the original injury plus applicable cost of living adjustments, and the relevant tax provisions at the time of recurrence. A second wage rate calculation based on the worker's earnings at the time of the recurrence must be done in accordance

with the *Act*. This enables the Board to determine which average earnings calculation best represents the worker's loss of earnings.

Where a worker does not fall within any of the exceptions provided for in sections 33.5 to 33.7 of the *Act* and it is determined that compensation is payable as if the recurrence were the happening of the injury such that a new wage rate is established based on the earnings at the time of recurrence, the initial payment period provided in section 33.1(1) of the *Act* will recommence.

1. **Temporary Disability Recurring After Three Years Where the Worker 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 recurrence of disability exceed the earnings rate originally set on the claim (or the review rate, if applicable) plus cost of living 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 award granted in respect of the original injury, section 32(2) applies. Therefore, the permanent disability periodic payment 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. (14) Where required under the *Act*, a 10-week rate review will be carried out. Any cost of living adjustments following the recurrence will be applied in accordance with section 25 of the *Act*.

   (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 review rate, if applicable), the previous rate will be used plus applicable cost of living 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 review rate, if applicable) plus

applicable cost of living adjustments, 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 review rate, if applicable) plus applicable cost of living 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 permanent disability award or higher award which the worker asked for should not be awarded because the worker was capable of undertaking certain occupations, it will not now be possible to conclude that the worker'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 worker, such as, for example, a voluntary change in lifestyle, the reduced earnings figure will be used on reopening to calculate the worker's wage rate. Section 32 will be applied and the rules set out in (a) above will apply in relation to the reduced figure.

(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 award granted in respect of the original injury, section 32(2) applies and the award 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. When required by the *Act*, a 10-week rate review is carried out. Since the 10-week review

generally permits a consideration of the 12 months immediately preceding the date of injury, it will have the effect of adjusting for the long term any temporary aberrations in earnings capacity caused by economic fluctuations.

Any cost of living adjustments occurring in the twelve months following the recurrence will, by virtue of section 25(3), not be applicable to the wage-loss payments being made.

2. **Temporary Disability Recurring After Three Years Where the Worker 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 wage rate originally set on the claim (or the review rate, if applicable) plus applicable cost of living 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 review rate, if applicable) plus applicable cost of living adjustments. In determining whether there is a "potential loss", the following are among the questions that might be considered.

(i) Was the worker's unemployment a matter of personal choice?

(ii) Does the worker's lifestyle render it unlikely that he or she will, in practice, obtain employment? For example, if the worker 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 Human Resources and Development 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 Human Resources?

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 awards. 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 permanent disability award assessed on a loss of function 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 cost of living adjustments. Permanent disability awards are distinguishable from wage-loss benefits since the awards concern the long term situation as opposed to the current situation. Refer to Chapter 6, Permanent Disability Awards, for a discussion regarding the methods of assessing permanent disability awards. 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. Even though a person is unemployed at the time of a section 23(1) assessment, 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.

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.

5. **Re-openings for Persons with Personal Optional Protection**

In the case of a reopening over three years from the date of injury:

- Where the person has maintained personal optional protection coverage at the time of reopening, the Board will determine the person's average earnings based on the current rate of coverage.

- Where the person no longer has personal optional protection, the Board will determine average earnings based on the initial personal optional protection rate plus the appropriate cost of living adjustments.

- Where the person is now employed in circumstances where there is compulsory coverage for worker so that the person is considered to be a worker under the *Act*, the rate on reopening will be based on the worker's current average earnings. An evaluation is required as to the impact of the original injury on the worker's current average earnings where the worker's average earnings are lower than the amount of personal optional protection the worker had at the time of the injury.

EFFECTIVE DATE: March 3, 2003 (as to deletion of references to recurrence and new injury)
APPLICATION: Not applicable.

#70.30 Permanent Disability Awards

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 policy item #69.11.

#71.00 AVERAGE NET EARNINGS

Effective June 30, 2002, compensation is based upon 90% of a worker's average net earnings.

Before calculating a worker's average net earnings, the Board determines the worker's average earnings. The process for determining a worker's average earnings is described in Chapter 9.

The Board establishes a worker's average net earnings by deducting the following items from the worker's average earnings:

(a) probable EI premiums;

(b) probable CPP contributions; and

(c) probable income taxes.

The Board does not consider the actual amounts deducted from a worker's pay cheque for the items listed in (a) – (c) above. Instead, the Board considers the probable deductions for these items.

Under sections 33.8 and 33.9 of the *Act*, the Board calculates a worker's average net earnings at two stages in the claim process as described below.

#71.10 Short-term Average Net Earnings

Under section 33.8 of the *Act*, short-term average net earnings apply to the period that begins on the date of the worker's injury and ends on the earlier of:

(a) the date temporary disability benefits have been payable to the worker for a cumulative period of 10 weeks; or

(b) the effective date of a permanent disability award.

Schedule of Deductions

Effective January 1st each year, the Board implements a schedule of deductions ("Schedule") for earning levels up to the statutory maximum. The Schedule reflects the federal and provincial income tax rates and the levels of CPP contributions and EI premiums in effect for the immediately preceding calendar year. As a result, any changes to these items during a calendar year are not reflected in the Schedule until January 1st of the following year.

The Board uses the Schedule to determine the CPP contributions, EI premiums and income taxes applicable to a worker's average earnings. As a result, all workers with the same average earnings have the same deductions made for CPP contributions, EI premiums and income taxes.

When calculating a worker's short-term average net earnings, the applicable Schedule is that which is in effect on the date of the worker's injury.

Probable CPP and EI

Deductions for probable CPP contributions and EI premiums are based on the requirements of the *Canada Pension Plan Act* and the *Employment Insurance Act*. When determining these deductions, the Board considers the contributions and premiums required under those *Acts* for the worker's average earnings. The Board does not consider the actual CPP contributions and EI premiums deducted from the worker's paycheque.

Probable Income Taxes

In estimating probable income taxes for short-term average net earnings, the Board applies only the following tax credits under the *Income Tax Act* and the *Income Tax Act* (Canada):

(a) credits based on the basic personal amounts, multiplied by 1.5; and

(b) credits for the probable CPP contributions and EI premiums payable for the worker's average earnings.

All workers receive tax credits equaling 1.5 times the basic personal amounts, regardless of actual tax status. As well, deductions for probable income taxes are made regardless of whether the worker is required to pay taxes under the *Income Tax Act* and the *Income Tax Act* (Canada).

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 worker'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 workers 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 Executive Director, Health Care Services.

2. The Executive Director, Health Care Services will review the case, together with a committee composed of the following members:

   (a) The Board's General Counsel, or nominee;

   (b) The Director, Clinical Services Department;

   (c) The Director, Rehabilitation Services.

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 worker 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 worker is not receiving proper treatment, the claim 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 worker examined at the Board.

2. Refer the worker 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 and since it is a decision that is reviewable by the Review Division, it must be communicated in writing by the Board officer to the worker and the chiropractor. When recording their opinions on claims, 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 memos 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 workers 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: March 3, 2003 (as to reference to review)
APPLICATION: Not applicable.

#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 worker.

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. Concurrent treatment is discussed in policy item #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.

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 (policy item #74.60) or a denial of an extension of chiropractic treatment (policy item #74.21) or physiotherapy (policy item #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 worker 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.

#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 Board officer in Vocational Rehabilitation Services; 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 item #100.12 or policy item #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 worker 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

Workers may, of their own accord, bypass adequate local treatment facilities to attend a practitioner of their own choice elsewhere. The *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 also apply with regard to expenses incurred in connection with a claims 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 considers 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 policy item #82.10.

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.

The amount of the kilometre rate is set out below:

Date	Amount Per Kilometre
January 1, 2002 – December 31, 2002	30¢
January 1, 2003 – December 31, 2003	31¢

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

Effective June 30, 2002, the kilometre rate will be adjusted on January 1 of each year. The percentage change in the consumer price index determined under section 25.2 of the *Act*, as described in policy item #51.20, will be used. 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 No. 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 Board officer 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.

Workers 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 policy item #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)

#83.11 Travelling Companions

The following general rules will apply with regard to subsistence payments 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 Board officer will authorize subsistence 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 Board officer. (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 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 or subsistence payments to visit with the injured worker, during the early stages of treatment and the fitting of a prosthesis. The Board officer responsible for the claim approves these visits.

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 Board officer 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 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 Rehabilitation and 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. 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.

5. Where the Board officer feels that there are other circumstances where subsistence 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 Board officer may request subsistence 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 worker is being treated, travelling expenses and subsistence allowances are payable.

The Board officer will normally accept the judgment of the attending physician as to whether a travelling companion should accompany the worker 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 policy item #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 90% 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 policy item #34.20 and policy item #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 *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 *Act*.

#83.20 Rates of Subsistence

"Subsistence" means the costs of accommodation and meals.

The Board will normally reimburse actual accommodation costs. 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, 2002 – December 31, 2002	$9.89	$12.19	$20.96	$43.04
January 1, 2003 – December 31, 2003	$10.20	$12.58	$21.62	$44.40

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 meal allowance will be adjusted on January 1 of each year.

Effective June 30, 2002, the percentage change in the consumer price index determined under section 25.2 of the *Act*, as described in policy item policy item #51.20, will be used.

The rules set out above apply equally to family members or other persons travelling with or visiting an injured worker.

#84.20 Right of Eligible Workers to Choose Own Accommodation

Patients are allowed a free choice as to whether they wish to stay at accommodations paid for by the Board 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 accommodations paid for by the Board and be informed of the medical opinion. But the patient will still be allowed the choice.

Patients who live outside the Lower Mainland area, but within the Fraser Valley, who come to the Rehabilitation Centre for treatment daily, will be offered accommodation. 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 policy item #83.20 to a worker who is eligible for paid accommodation 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 worker will receive the appropriate subsistence allowance if he or she chooses to live there.

#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 circumstance.

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 worker'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 Board officer in Vocational Rehabilitation Services is responsible for the investigation of the worker's circumstances and ongoing monitoring.

The allowance will normally be paid to the worker.

NOTES

(1) S.6(1); See policy item #26.30

(2) ~~See policy item #75.11~~ **DELETED**

(3) See policy item #78.22

(4) S.1

(5) S.56; See policy item #95.00

(6) S.56(2); See policy item #78.00

(7) S.56(4)

(8) S.21(2)

(9) See policy item #78.20

(10) See policy item #74.60

(11) See policy item #77.00

(12) See policy item #78.20

(13) ~~See policy item #73.10~~ **DELETED**

(14) ~~See Chapter 16~~ **DELETED**

(15) S.21(9)

(16) S.21(6)

(17) S.21(6)

(18) See policy item #22.11

(19) S.21(6)

(20) S.21(6)

(21) See policy item #80.00

(22) Decision 324

(23) See policy item #74.00 for the difference between “physician” and “qualified practitioner”

(24) See policy item #48.40

(25) S.21(3)

(26) S.21(1)

(27) See policy item #68.22

(28) ~~See policy item #84.10~~ **DELETED**

(29) ~~See policy item #84.11~~ **DELETED**

(30) See policy item #83.11 **DELETED**

RE: Vocational Rehabilitation - Eligibility Criteria **ITEM: C11-86.00**

BACKGROUND

1. Explanatory Notes

This policy sets out eligibility criteria for vocational rehabilitation services.

2. The Act

Section 16:

(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. ….

Section 22:

(1) … if a permanent total disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment that equals 90% of the worker's average net earnings.
….

Section 29:

(1) … if a temporary total disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment that equals 90% of the worker's average net earnings. ….

Section 30:

(1) … if a temporary partial disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment that equals 90% of the difference between

(a) the worker's average net earnings before the injury, and

(b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:

(i) the average net earnings that the worker is earning after the injury;

(ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury. ….

Section 23:

(1) Subject to subsections (3) to (3.2) …, if a permanent partial disability results from a worker's injury, the Board must

(a) estimate the impairment of earning capacity from the nature and degree of the injury, and

(b) pay the worker compensation that is a periodic payment that equals 90% of the Board's estimate of the loss of average net earnings resulting from the impairment. …

(3) … if

(a) a permanent partial disability results from the a worker's injury, and

(b) the Board makes a determination under subsection (3.1) with respect to the worker,

the Board may pay the worker compensation that is a periodic payment that equals 90% of the difference between

(c) the average net earnings of the worker before the injury, and

(d) whichever of the following amounts the Board considers better represents the worker's loss of earnings:

(i) the average net earnings that the worker is earning after the injury;

(ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury.

(3.1) A payment may be made under subsection (3) only if the Board determines that the combined effect of the worker's occupation at

the time of the injury and the worker's disability resulting from the injury is so exceptional that an amount determined under subsection (1) does not appropriately compensate the worker for the injury.

(3.2) In making a determination under subsection (3.1), the Board must consider the ability of the worker to continue in the worker's occupation at the time of the injury or to adapt to another suitable occupation.

POLICY

Eligibility

Rehabilitation assistance may be provided in cases where it appears to the Board officer in Vocational Rehabilitation Services that such assistance may be of value, and where a decision has been made that the injury, occupational disease or death is compensable.

Eligibility for vocational rehabilitation services will be determined in relation to the entitlement provisions of the *Act* as follows:

Temporary total disability

Vocational rehabilitation services are usually not provided to a worker with a temporary total disability, as the worker's medical condition often precludes the necessity of vocational rehabilitation initiatives. Limited vocational rehabilitation services may be considered where the Board officer in Compensation Services determines that such services will assist in the worker's recovery or in making selective/light employment arrangements.

Temporary partial disability

Vocational rehabilitation services may be made available to a worker who is no longer considered to be "totally" disabled from working in the pre-injury occupation. The worker is considered capable of returning to a suitable occupation but may require vocational rehabilitation assistance to maximize short-term earning capacity up to the pre-injury wage rate.

Eligibility arises where:

- the compensable condition necessitates vocational rehabilitation assistance in early and safe return to work in the pre-injury occupation or a suitable occupation available over the short term;

- the compensable condition is complicated by non-compensable factors, the combination of which creates an impediment to return to work over the short term, necessitating assistance in an early and safe return to the pre-injury occupation or a suitable occupation;

- the pre-injury job is no longer available due to the injury and the worker requires assistance to return to work in a suitable occupation.

Permanent partial disability (section 23(1))

Vocational rehabilitation services may be provided where a worker's temporary disability has ceased and his or her medical condition has stabilized. Workers with a section 23(1) award are generally able to return to their pre-injury occupation or another suitable occupation but may need assistance in their return to the workforce.

Eligibility arises where:

- the compensable condition necessitates vocational rehabilitation to assist the worker in his or her efforts to return to the pre-injury occupation;

- the compensable condition is complicated by non-compensable factors, the combination of which creates an impediment to return to work, necessitating assistance in his or her efforts to return to the pre-injury occupation or another suitable occupation;

- the pre-injury job is no longer available due to the injury and the worker requires assistance to return to another suitable occupation.

Permanent partial disability (section 23(3))

Vocational rehabilitation services may be provided to a worker who is entitled to a section 23(3) assessment for permanent partial disability and the worker requires assistance in his or her efforts to return to the workforce in another suitable occupation and maximize long-term earning capacity up to the pre-injury wage rate.

Permanent Total Disability

Vocational rehabilitation services will be provided to a worker with a permanent total disability where the worker needs assistance in improving his or her quality of life. It may include assessment of a worker's need or continued need for rehabilitation and health care services and supports, where a worker's permanent total disability will continue past retirement age.

Non-compensable Problems

Where a 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.

Third-Party Claims

In the case of third-party claims, where a worker has a right of election, a worker is not eligible for rehabilitation assistance until the worker has elected to claim compensation with the Board.

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.

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:	ss. 16, 22, 23, 29, 30 and 96.2 of the *Act*.
CROSS REFERENCES:	Selective/Light Employment (policy item #34.11), Vocational Rehabilitation - Referral Guidelines (policy C11-86.10), Injury Not Caused by Worker or Employer (policy item #111.20), and Retirement Benefits - Retirement Services and Personal Supports (Policy C18-116.30) of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	Replaces policy items #86.00, #86.20, #86.40 and #86.70 of the *Rehabilitation Services & Claims Manual*, Volume II. The effective date of this Item was November 1, 2002. Effective March 3, 2003, the policy in this Item was amended to remove the reference to appeal and include a reference to review, consequential to the *Workers Compensation Amendment Act (No.2), 2002*.
APPLICATION:	To decisions made on or after November 1, 2002 on claims adjudicated under the *Act,* as amended by the *Workers Compensation Amendment Act, 2002*. To decisions made on or after March 3, 2003 as to requests for review by the Review Division.

RE: Vocational Rehabilitation - Referral Guidelines **ITEM: C11-86.10**

BACKGROUND

1. Explanatory Notes

This policy sets out referral guidelines for vocational rehabilitation services.

2. The Act

Section 16:

> (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. ….

POLICY

Referral Guidelines

The following guidelines are used by Board officers in making referrals to the Board officer in Vocational Rehabilitation Services. Internal Board referrals should clearly identify what has been accepted under the claim and specify reasons for the referral, including new information warranting repeat referral.

Workers may also be referred directly by physicians, hospitals, union representatives, employers and other agencies, or may seek assistance themselves.

Immediate Referrals

The following require immediate referral:

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.

General Referrals

1. Claims meeting the eligibility criteria.

2. Employability assessments for the consideration of temporary partial disability benefits under section 30 of the *Act*.

3. Employability assessments for the consideration of permanent partial disability under section 23(3).

4. Consideration for continuity of income benefits.

5. Commutation investigations.

6. Reviews under section~~s 23(3) or~~ 24.

7. Consideration of a permanently totally disabled worker's need or continued need for rehabilitation and health care services and personal supports in the three month period prior to the receipt of a retirement benefit.

8. Consideration for Homemakers' Services.

9. Consideration for Personal Care Allowances.

10. Consideration for Independence and Home Maintenance Allowances.

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.

Out of Province Referrals

Rehabilitation services requested of, or by, other Canadian Boards and Commissions are coordinated through reciprocal inter-jurisdictional agreement.

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:	Section 16 of the *Act*.
CROSS REFERENCES:	ss. 21, 22, 23, 24 and 30 of the *Act;* and Procedure for Determining Whether Worker is Temporary Partially Disabled (policy item #35.11), Section 23(3) Assessment Formula (policy item #40.10), Suitable Occupation (policy item #40.12), Reviews of Permanent Partial Disability Awards under Section 23(3) (policy item #40.30), Decision-Making Procedures (policy item #45.50), Review of Old Pensions under Section 24 (policy item #46.00), Personal Care Expenses or Allowances (policy item #80.00), Independence and Home Maintenance Allowance (policy item #81.00), Homemakers Services (policy item #84A.00), Vocational Rehabilitation - Eligibility Criteria (policy C11-86.00), Vocational Rehabilitation - Employability Assessments – Temporary Partial Disability and Permanent Partial Disability (policy C11-89.00), and Retirement Benefits - Retirement Services and Personal Supports (policy C18-116.30) of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	Replaces policy items, #86.10, #86.11, #86.12, #86.50, #86.60, and #86.80 of the *Rehabilitation Services & Claims Manual*, Volume II. The effective date of this Item was November 1, 2002. Effective March 3, 2003, the policy in this Item was amended to remove the reference to a review of a section 23(3) permanent partial disability award, consequential to the *Workers Compensation Amendment Act (No. 2), 2002*.
APPLICATION:	To decisions made on or after November 1, 2002 on claims adjudicated under the *Act,* as amended by the *Workers Compensation Amendment Act, 2002*.

RE: Vocational Rehabilitation - Income Continuity	ITEM: C11-89.10

BACKGROUND

1. Explanatory Notes

This policy deals with the payment of a rehabilitation allowance pending the assessment of a permanent disability award under section 23(3).

2. The Act

Section 16:

> (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. ….

Section 23 provides, in part:

> (3) … if
>
> (a) a permanent partial disability results from the a worker's injury, and
>
> (b) the Board makes a determination under subsection (3.1) with respect to the worker,
>
> the Board may pay the worker compensation that is a periodic payment that equals 90% of the difference between
>
> (c) the average net earnings of the worker before the injury, and
>
> (d) whichever of the following amounts the Board considers better represents the worker's loss of earnings:
>
> (i) the average net earnings that the worker is earning after the injury;

(ii) the average net *earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury*. (emphasis added)

(3.1) A payment may be made under subsection (3) only if the Board determines that the combined effect of the worker's occupation at the time of the injury and the worker's disability resulting from the injury is so exceptional that an amount determined under subsection (1) does not appropriately compensate the worker for the injury.

(3.2) In making a determination under subsection (3.1), the Board must consider the ability of the worker to continue in the worker's occupation at the time of the injury or to adapt to another suitable occupation.

POLICY

Continuity of Income Pending Assessment of Permanent Disability Award

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 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 a permanent partial disability award under section 23(3) of the *Act*

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 award under section 23(3). These income continuity payments will be considered by the Board officer in Vocational Rehabilitation Services following discussions with appropriate Board officers.

Prior to implementing an income continuity payment, the Board officer in Vocational Rehabilitation Services must have considered and offered to the

worker all rehabilitation measures which are reasonable and might be of assistance to the worker.

Amount of Payment

Continuity of income payments are based initially on the same rate as the wage-loss benefit rate and will continue at that level until the permanent disability award is granted, 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 Board officer in Vocational Rehabilitation Services will complete the employability assessment required under section 23(3), 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 Board officer 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 Board officer will not adjust the rate at this point if, during the 30-day period based on new evidence, the Board officer decides the employability assessment requires revision.

As part of the completion of the employability assessment and prior to adjusting the income continuity rate, the Board officer 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.

Permanent Disability Award Reopenings

Continuity of income payments will also be considered for workers who are already receiving a permanent disability award on the claim, where the Board has reopened the award decision and it is likely that the worker will receive a significant increase in the award. 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 reopening. Benefit levels will be established in accordance with this policy.

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:	ss.16 and 23(3) of the *Act*.
CROSS REFERENCES:	Suitable Occupation (policy item #40.12), and Vocational Rehabilitation - Employability Assessments – Temporary Partial Disability and Permanent Partial Disability (policy C11-89.00) of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	Replaces policy items #89.11 and #89.13 of the *Rehabilitation Services & Claims Manual,* Volume II. The effective date of this Item was November 1, 2002. Effective March 3, 2003, the policy in this Item was amended to reference a reopening of a permanent disability award, consequential to the *Workers Compensation Amendment Act (No. 2), 2002*.
APPLICATION:	To decisions made on or after November 1, 2002 on claims adjudicated under the *Act*, as amended by the *Workers Compensation Amendment Act, 2002.*

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).

#93.20 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 policy item #31.30. In the case of occupational diseases, reference should be made to policy items #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 policy item #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 policy item #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, since the distinction may affect the rights of appeal which a person has to challenge the decision. 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 worker. 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 worker'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 worker'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 worker did suffer a genuine work injury.

   The following facts illustrate a situation where special circumstances were found to exist. The worker 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 worker 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 worker 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 worker 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 worker'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 worker from submitting his application within the one-year period, the Board decided to exercise its discretion against allowing the worker'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 worker'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 worker'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. (5)

In accordance with this provision, a Board officer may pay all the compensation due on a claim without first receiving an application from the worker. However, the Board officer 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. Board officer can however exercise discretion where the circumstances warrant a deviation from this requirement.

A Board officer 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.

#93.25 Signature on an Application for Compensation

The application for compensation must be signed by the worker. (6) 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 worker 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 worker 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 worker'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. (7)

#93.26 Obligation to Provide Information

Section 57.1 of the *Act* provides as follows:

(1) A worker who applies for or is receiving compensation must provide the Board with the information that the Board considers necessary to administer the worker's claim.

(2) If a worker fails to comply with subsection (1) the Board may reduce or suspend payments to the worker until the worker complies.

The Board operates under an inquiry system and as such, reasonable efforts are made to obtain information directly from the source. However, it is recognized that, in the course of administering a claim, the Board may have to rely on a worker to obtain relevant information.

A worker's obligation to provide information may arise at any time during the claim cycle. Necessary information includes, but is not limited to, information related to the worker's compensable disability, pre and post-injury earnings, tax status and Canada Pension Plan disability benefits.

The Board will set a timeframe for the worker to provide the necessary information. The timeframe may vary depending upon the nature of the information requested. However, it should not extend past 30 days, except where the Board is satisfied that the worker is making best efforts to obtain the necessary information.

Where the Board requires information from a worker that it considers necessary to administer the worker's claim, notification must be provided in writing. Notification to the worker must specify:

- what information is required;
- the worker's obligation to provide the information;
- the timeframe for compliance; and
- the consequences for failing to comply.

The Board may reduce or suspend a worker's payments if, after providing written notification of the obligation to provide necessary information and the consequences of failing to comply, the worker:

- fails or refuses to supply the information within the specified timeframe; and
- does not have a valid reason for failing to comply.

If a worker has to obtain the information from a third party (e.g., Human Resources Development Canada or Canada Customs and Revenue Agency), the Board must be satisfied that the worker failed to take all reasonable steps to acquire the information before determining that a worker has failed to comply.

The Board recognizes that, in the course of obtaining requested information from third parties, certain fees may be levied. In these cases, the Board will provide reimbursement for necessary and reasonable costs incurred by the worker.

When a worker fails to fulfill the obligation to provide information, the Board will determine whether there was a valid reason. Payments will not be reduced or suspended for non-compliance if there is a valid reason acceptable to the Board, such as a sudden illness or a death in the family.

Once the worker has fulfilled his or her obligation to provide information, the Board will restore payments for any period for which they were reduced or suspended.

This policy does not restrict the Board from pursuing all available courses of action in response to fraud or misrepresentation.

#93.30 Medical Treatment and Examination

The obligations of an injured worker to undertake medical treatment and examination are discussed in policy item #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 policy item #35.00

#94.00 RESPONSIBILITIES OF EMPLOYERS

#94.10 Report to the Board

Subject to policy items #94.12 and #94.13, 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 policy items #94.12 and #94.13, an employer shall report to the Board within three days of receiving information under section 53, (8) 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. (9)

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 No. 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 worker.

#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 policy item #94.12, or when notification of any such condition is received by mail or telephone at the local or head office of the employer. (10)

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 Form 7 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 . . ." policy item #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). (11)

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 worker 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 (12) 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 sections 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 sections 96(4) and (5))

APPLICATION: Not applicable.

#94.20 Employer or Supervisor Must Not Attempt to Prevent Reporting

Section 177 of the *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 (13) 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. (14)

#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 policy item #95.00. (15)

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. (16)

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 worker was disabled. The best evidence of that disability is almost always medical evidence, but on some occasions, evidence from the worker 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. (17)

#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: March 3, 2003 (as to deletion of references to how policy is to be applied)
APPLICATION: Not applicable.

#96.20 Board Officers

A Board officer determines whether compensation is payable. They will decide, for instance, whether a worker 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 worker 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 permanent disability 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: March 3, 2003 (as to deletion of reference to interim measures)
APPLICATION: Not applicable.

#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. (19)

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 a 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 file will simply be marked "nothing to consider".

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 (see policy item #93.26 regarding a worker's obligation to provide information).

Where a claim file 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 file will be placed in suspense. (20)

Wage-loss benefits may also be suspended in the following situations:

(1) where the worker leaves the province without notifying the Board or receiving prior consent from the Board; (21)

(2) where the worker is being paid full salary by the Federal Government; (22)

(3) where the worker 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.

#96.30 Disability Awards Officers and Adjudicators in Disability Awards

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 permanent disability award 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 policy 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 policy item #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 permanent disability award entitlement.

The final decision on the assessment of a permanent disability award 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 permanent disability awards are adjudicated in the first instance by Adjudicators in Disability Awards. Before making a decision, they may ask the Rehabilitation Consultant to contact the worker and obtain the necessary information.

#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 Board officer 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 worker, 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 worker, 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 worker'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 worker, it can fairly be said that the claim has not been established. The worker 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 worker 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. (23)

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. (24)

(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. (25)

(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. (26)

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, (27) 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 Worker about His or Her Own Condition

A statement of a worker about his or her own condition is evidence insofar as it relates to matters that would be within the worker'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 worker about his or her own condition must be corroborated. The absence of corroboration is, however, a ground for considering whether the worker should be interviewed by the Claims Adjudicator or Claims Officer, or telephone enquiries made, or whether anything relevant could be discovered by having the worker examined by a Board Medical Advisor. A conclusion against the statement of the worker 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 worker, or if the statement of the worker 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 worker suffering from silicosis would be worthless; but a statement by a fellow worker reporting to have seen the worker 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. (28)

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. (29)

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 worker 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 #39.01.

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: To decisions made on or after January 1, 2003.

#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. (30)

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. (31)

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. (32) 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 Division 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 Board officer visits the work place to investigate a claim, the worker, 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 worker has a right to bring a representative to any enquiry, both at first instance and on appeal.

If the worker is unable to communicate effectively in English, an interpreter is arranged.

#98.24 Presence of Employer

If a worker is unrepresented, and the employer or employer's representative appears, it must be determined whether the employer is appearing on behalf of the worker. If the employer is appearing on behalf of the worker, the worker 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 worker does object, the employer will be asked to wait outside, and can be interviewed separately.

If appearing against the worker, the employer is not allowed to be present at the interview with the worker and must be interviewed separately. If there is any

doubt as to the employer's intentions, the employer will be interviewed separately.

If a worker is represented, an employer may be permitted to be present even if the employer is appearing against the worker.

#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,

the person shall, instead of taking an oath, make an affirmation. (33) An employer or representative or a worker'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 worker 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 worker being present. They will not be present while the worker 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 ("WCB"), 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) 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 the 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)

Policy Item	Description	F.I.P.P. Reference	Other Reference
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

Policy Item	Description	F.I.P.P. Reference	Other Reference
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 Permanent Disability 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

Policy Item	Description	F.I.P.P. Reference	Other Reference
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)	

Policy Item	Description	F.I.P.P. Reference	Other Reference
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)	

Policy Item	Description	F.I.P.P. Reference	Other Reference
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. (34) 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 worker. These communications may be by telephone, in person or in writing. Through the medium of these communications the worker 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 worker is contacted before a decision is reached. The contact provides the worker with an opportunity for input and comment. In situations involving serious cases or complex issues where no prior contact has been made with the worker, 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 worker'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 worker 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 worker.

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 worker'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 worker 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 worker's union or association is acting on behalf of the worker. 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 policy item #99.35 - Complaints Regarding File Contents.

#99.24 Notification of Permanent Disability 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 permanent disability award 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 worker 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 worker.

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 worker, 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 worker, 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 worker 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 permanent disability award being paid to a worker 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 policy item #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. 321/2000) 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 policy item #82.10 and policy item #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 worker, 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 may be offered if required. Policy item #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 policy item #82.20 (transportation), policy item #83.20 (meals and accommodation) and policy item #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 worker, 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 references 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 worker 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 worker 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 worker. 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.

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. (36) The Board will not pay the legal costs of a worker 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 worker incurs expense in producing evidence of a kind which the Board officer would have sought had it not been produced by the worker, 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 worker and the fees of the lawyer or representative for work done. Only the former are reimbursable.

The cost of medical reports obtained by a worker 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 worker'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 worker's attending

physician at no cost. A simple request to the attending physician, together with a release from the worker, would have been sufficient.

It is not the Board's intention that workers or employers should incur costs in obtaining evidence, for example, accountants' fees for producing earnings information. Rather, the general approach is that the worker or employer should advise the Board of possible sources of information and the Board should carry out the necessary inquiries. This may, for example, require the Board to request that the worker provide information considered necessary to administer the claim (see policy item #93.26).

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 policy item #100.00 to policy item #100.50. 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 Decision 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 award. 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 of 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 or 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 request a review 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 the 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 policy item #94.11

(4) *Workers' Compensation Board of British Columbia, W.C.B. News*, November – December, 1975, 4

(5) S.55(1)

(6) S.55(1)

(7) S.12; See policy item #49.00

(8) S.54(2)

(9) S.54(3)

(10) S.54(6)(b)

(11) S.54(9)

(12) See policy item #34.40

(13) See policy item #74.10

(14) S.56(1)(b)

(15) S.56(1)(c)

(16) S.56(5)

(17) S.56(1)(d)

~~(18) S.99~~ **Deleted**

(19) See Chapter 16

(20) See policy item #112.30; policy item #113.30

(21) See policy item #73.54

(22) See policy item #34.40

(23) *Workers' Compensation Board of British Columbia, W.C.B. News Bulletin*, September – October, 1973

(24) S.5(4); See policy item #14.10

(25) S.6(3); See policy item #26.21

(26) S.6(11); See policy item #29.50

(27) See policy item #95.10

(28) See policy item #97.10

(29) See policy item #74.60

(30) S.88(2)

(31) S.88(4)

(32) S.88(5)

(33) S.21, *Evidence Act*

(34) S.95(2)

~~(35) See policy item #103.00~~ Deleted

(36) See policy item #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 C-13-104.00

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.

#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

There is no POLICY for this Item.

PRACTICE

There is no PRACTICE for this Item.

EFFECTIVE DATE:	March 3, 2003
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:	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– 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, 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 allows further compensation or rehabilitation to be paid or provided subsequent to, and as a result of, the change or recurrence. 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) A recurrence of injury is not a new injury

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.

"Recurrence" refers to a recurrence of the original injury without a second compensable injury. 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.

(e) 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 under this provision may be appealed directly to the Workers' Compensation Appeal Tribunal.

The effect of these provisions is that the preliminary or threshold question whether the grounds for a reopening 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 WCAT.

However, 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 WCAT under section 239(1).

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:	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:	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 – 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 errors 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.

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:	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:	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 – 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)

#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 permanent disablity award where the indebtedness may be recovered from the permanent disablity award capital reserve.

#111.30 Meaning of "Worker" and "Employer" under Section 10

In the provisions discussed in policy items #111.10 to #111.24, "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 No. 223).

#111.50 Federal Government Employees

The provisions discussed in policy item #111.00-40 above have no application to employees entitled under the *Government Employees Compensation Act*.

Rules similar to those set out in policy item #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 *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 policy items #112.10 and #112.20.

The payment of health care benefits for costs incurred outside the province is discussed in policy item #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 policy item #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 policy item #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; policy item #49.00

(5) policy item #93.20

(6) S.10(5)

(7) policy item #93.20

(8) S.10(6)

(9) S.10(11)

(10) S.10(9); S.3(3)

(11) See policy item #14.00

(12) See policy item #113.30

(13) S.9(2)

(14) policy item #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 worker'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 *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. Until September 27, 2002, 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. Effective September 28, 2002, 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 10 weeks.

2. Until September 27, 2002, an assessment of the worker's work exposure history is then made and an apportionment of the costs incurred beyond 13 weeks, including the amount of any permanent disability award 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 worker'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.

Effective September 28, 2002, an assessment of the worker's work exposure history is then made and an apportionment of the costs incurred beyond 10 weeks, including the amount of any permanent disability award 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 10 weeks, which is attributable to the worker'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. Until September 27, 2002, 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.

   Effective September 28, 2002, where any portion attributable to any employer at the time the claim is submitted is less than 20%, the costs incurred following 10 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 worker'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 Board officer responsible for handling silicosis or pneumoconiosis 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 or 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 Board officer responsible for silicosis or 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 *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 *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 worker'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.

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 Board officer 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 Board officer 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 Board officer 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.

#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 policy item #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 policy item #44.31, section 5(5) can also apply if a permanent disability award is being assessed on a loss of earnings basis under section 23(3) of the *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 worker. 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 worker. It can apply in cases where section 5(5) does not apply and the whole of the worker'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 worker'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 worker's body.

#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 policy item #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 policy item #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: Not applicable.

#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.

#115.00 PROVISIONS CHARGING INDIVIDUAL EMPLOYERS

One provision of this nature has been discussed in policy item #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 Policy No. 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.

Policy 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 Revision Division with respect to the acceptance of the claim.

EFFECTIVE DATE: March 3, 2003 (as to references 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. Until September 27, 2002, costs after 13 weeks where section 5(3) applies (see policy item #16.60). Effective September 28, 2002, costs after 10 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 permanent disability award 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 deletion of references to the Review Board 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 award 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 policy item #31.20

(2) See Policy No. 20:30:40 *Assessment Policy Manual*

~~(3) See policy item #112.30~~ Deleted

~~(4) See policy item #82.40~~ Deleted

~~(5) See policy item #82.40~~ Deleted

~~(6) S.96(6) and 96(7)~~ Deleted