

## **CHAPTER 10**

### **MEDICAL ASSISTANCE**

#### **#72.00 INTRODUCTION**

Section 21(1) of the Act provides in part as follows:

“In addition to the other compensation provided . . . , the board may furnish or provide for the injured worker any medical, surgical, hospital, nursing and other care or treatment, transportation, medicines, crutches and apparatus, including artificial members, that it may consider reasonably necessary at the time of the injury, and thereafter during the disability to cure and relieve from the effects of the injury or alleviate those effects, and the board may adopt rules and regulations with respect to furnishing health care to injured workers entitled to it and for the payment of it.”

Under Section 21, the Board is responsible for the cost of health care benefits for compensable injuries and occupational diseases. This includes necessary hospitalization, treatment provided by recognized health care professionals, prescription drugs and necessary medical appliances.

#### **#73.00 RIGHT OF WORKER TO HEALTH CARE BENEFITS**

Health care benefits are provided on accepted claims for compensation from the date of injury. They are provided even though the worker is not disabled from earning full wages at the work at which he or she was employed. (1)

Where a worker who is not disabled from working loses time from work to attend treatment or be examined, the worker may be eligible to receive income-loss payments equivalent to wage-loss benefits. This entitlement is fully explained in #83.13.

##### **#73.10 Prior to Adjudication**

A worker will often receive treatment prior to the adjudication of the claim. If this treatment takes place at the Board's Rehabilitation Centre, the Board will meet the cost, whether or not the claim is later accepted. With regard to treatment received elsewhere, the costs are paid only when the claim is accepted. (2)

The Board may pay for medical examinations or consultations on an investigative basis to assist in the adjudication of a claim. (3) However, if the investigation shows that the claimant's condition is not compensable, the Board

will not pay wage-loss for the period of the investigation simply because it has paid for health care benefits.

### **#73.20 Duration of Medical Assistance**

Coverage for necessary health care continues for as long as the worker continues to experience the effects of a compensable injury or occupational disease, notwithstanding that he or she may not be disabled from working or may be retired from the workforce.

### **#73.30 Suspended Claims**

No authorization for treatment may be given and no health care benefits are paid for the time that a claim is under suspension. If the claim is subsequently accepted, health care benefits incurred during the suspension are then paid.

### **#73.40 Approved Health Care Plans/Canada Shipping Act**

Section 21(4) provides that "Where a worker received, before April 1, 1972, health care under

(a) the *Canada Shipping Act* (Canada); or

(b) a health care plan approved by the board,

the worker is entitled to receive, in accordance with this section, additional health care."

As a result of this provision, health care benefits can be provided whether or not the worker is also entitled to such benefits under the *Canada Shipping Act*.

The Act previously allowed for the provision of health care benefits by employers under plans approved by the Board. The plans have now all been discontinued. Under the cancelling agreements, some of the employers are required to pay health care benefits in respect of injuries which occurred prior to the date of cancellation.

### **#73.50 Out-of-Province Treatment**

#### *#73.51 Injury Outside the Province*

For employees of railways, transportation companies, trucking companies, and other personnel whose business may take them to other provinces, emergency medical treatment is allowed at the rates applicable in the locality where it is given. However, this is only for such period as the worker's condition prevents a return to British Columbia. If it appears that treatment will be prolonged, consideration will be given to arranging the return of the worker to British Columbia.

### *#73.52 Worker Injured Near the Provincial Border*

Where the worker is a resident of British Columbia and the nearest health care available is in a province, state or territory adjacent to British Columbia, health care benefits may be paid at the rates applicable in that jurisdiction for treatment of short-term disabilities. Subsequent early transfer to British Columbia will be considered in more serious cases.

If, however, a worker injured near the provincial border bypasses available facilities in British Columbia, and by way of personal choice elects to receive treatment outside the province, the Board will not pay in excess of British Columbia rates for that treatment. For instance, this could apply if a worker resident outside the province, but working and injured within its borders, bypassed available and convenient British Columbia facilities and used out-of-province facilities near home.

### *#73.53 Worker Leaves the Province to Obtain Specialized Treatment*

It may be necessary to transfer a patient from British Columbia to another province or country for specialized treatment. In such cases, the rates applying in the area where the specialized treatment is carried out are payable, if the transfer is authorized by the Board.

### *#73.54 Worker Voluntarily Leaves the Province*

If a worker during treatment desires to leave British Columbia, either temporarily or permanently, the worker is required to discuss the treatment ramifications with the Board. Where leaving the province may impede the worker's recovery, the worker will be discouraged from doing so, and benefits may be suspended pursuant to #78.12 or #78.13.

The Board will generally not pay in excess of British Columbia rates for health care rendered outside the province to a claimant who has voluntarily left the province.

## **#74.00 PHYSICIANS AND QUALIFIED PRACTITIONERS**

A claimant is entitled to the services of a physician or qualified practitioner. A "physician" is any person registered under the *Medical Practitioners Act* and a "qualified practitioner" is a person registered under the *Podiatrists Act*, the *Chiropractors Act*, the *Dentists Act*, or the *Naturopaths Act*. (4) Thus, the services of medical practitioners, podiatrists, chiropractors, dentists, and naturopathic physicians are covered by the Act. Under Section 21, the Board reserves the right to determine if any particular form of treatment, or provider of treatment, is one that should be recognized for the care of a claimant.

## **#74.10 General Position of Physicians and Qualified Practitioners**

Physicians and qualified practitioners are required to submit reports to the Board regarding the nature of the worker's condition, the treatment program, the progress of the claimant and to advise and assist workers in making application for compensation. (5)

Every physician or qualified practitioner who is authorized to treat an injured worker is subject to like duties and responsibilities, and any health care furnished by such person shall be subject to the direction, supervision, and control of the Board. (6)

Physicians, qualified practitioners, or other persons authorized to render health care shall confine their treatment to injuries to the parts of the body they are authorized to treat under the statute under which they are permitted to practice, and the giving of any unauthorized treatment is an offence. (7) The maximum fine for committing this offence is set out in Part 1 of Appendix 6 to this manual.

Where, in a case of emergency, or for other justifiable cause, a physician or qualified practitioner other than the one provided by the Board is called in to treat the injured worker, and if the Board finds there was a justifiable cause and that the charge for the services is reasonable, the cost of the services shall be paid by the Board. (8)

### **#74.11 *Medical Negligence or Malpractice***

During the progress of a claimant's file, information may come to the attention of Board employees that would lead them to conclude that there was prima facie evidence of medical malpractice or negligence. This may come from the perusal of a single file or the perusal of a series of files where claimants have been treated by the same physician. The following action should be taken in these cases:

1. Where this is brought to the attention of a Board employee or a Board physician, it shall be reported to the Vice-President, Medical Services Division.
2. The Vice-President, Medical Services Division will review the case, together with a committee composed of the following members:
  - (a) The Board's General Counsel, or nominee;
  - (b) The Director, Medical Services Department;
  - (c) The Director, Rehabilitation Centre.

3. The committee will forward to the President a recommendation for action in cases where it is felt that medical malpractice or negligence may have occurred. The President will determine whether to proceed with an action. The claimant will be advised of the President's decision with reasons.

## **#74.20      Chiropractors**

### *#74.21      Duration of Treatment*

After eight weeks of treatment by a chiropractor, or earlier if there is any ground for suspecting that the claimant is not receiving proper treatment, the file must be referred to a Board Medical Advisor for review. The Board Medical Advisor will decide whether a continuance of treatment by the chiropractor should be authorized. It is necessary when such a request is received that the medical factors be considered and the various options evaluated. The main options which should be considered in order of preference are:

1. Have the claimant examined at the Board.
2. Refer the claimant for an orthopaedic or other appropriate specialist consultation.
3. Agree to an extension.

Giving preference to an examination by a Board Medical Advisor is simply an effective method of determining whether options 2 or 3 are necessary or appropriate, or whether some other approach or decision is indicated.

The third option is generally limited to situations where recovery appears imminent. The Board Medical Advisor should be satisfied that the worker's condition is improving. The duration of additional chiropractic treatment must be clearly designated, including the frequency of the treatments. Any extension should be limited to a maximum of four weeks. Where a request is received for an extension beyond this point, approval cannot be granted unless an examination is carried out by a Board Medical Advisor or there has been a specialist consultation. It is expected that extensions beyond 12 weeks would only occur in rare and unusual circumstances.

The reasons for accepting or denying a request for an extension of chiropractic care must be recorded on the claim file and since it is a decision that is reviewable by the Review Division, it must be communicated in writing by the Adjudicator to the claimant and the chiropractor. When recording their opinions on claim files, Board Medical Advisors should clearly define the reasons in support of their recommendations by outlining in what way an extension may produce an improvement in the worker's condition, or alternatively, why further treatments are likely to be ineffective. Under no circumstances should Board Medical Advisors make statements in the claim file such as, "I don't think this should be denied unless it is too frequent" or "I have no objection to chiropractic treatment if the worker thinks it is going to help."

Situations are occasionally met where claimants receive chiropractic treatments on a long-term basis (for example, one treatment per month for six to twelve months). Such treatments are probably more in the nature of preventative measures or as a means of forestalling future problems. The purpose of section 21 of the *Act* is to provide health care benefits for the treatment of injuries or occupational disease. As such, long-term chiropractic manipulation of this type will not be considered acceptable.

As a general rule, the Board will not pay for more than one treatment by a chiropractor per day. Any exception to this rule should normally be authorized beforehand by the Board. No exception will be allowed on the grounds that the additional treatment is needed to compensate for the bad effects of the journey to the chiropractor when, by seeking treatment from another chiropractor or different type of practitioner at a different location, the journey could have been avoided.

The Board will also not pay for daily treatment nor for house visits after the initial treatment unless the necessity is clearly indicated.

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

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

**APPLICATION:** Applies on or after October 1, 2007

#### *#74.22 Scope of Chiropractic Treatment*

The Board has established the guidelines set out below regarding the acceptability of chiropractic treatment.

1. Where chiropractic treatment is directed at the spinal column in respect of complaints in the extremities for which a claim has been accepted, the Board may refuse responsibility for the treatment if it concludes that the injury at work did not affect the spine, but was to the extremities only.
2. Where chiropractic treatment is directed at the spinal column for problems in an extremity and it is accepted that the work injury caused the condition of the spinal column, the treatment may be acceptable if it is concluded that the problem in the extremity arose from that condition.
3. Treatment by a chiropractor to the spine or any other articulations of the body must be reasonable and acceptable treatment for the medical problem experienced by the claimant.

4. Chiropractic treatment to the spinal column is not acceptable where:
  - (a) there is clinical evidence to suggest nerve root pressure with definite and progressive neurological findings; or
  - (b) there are fractures, dislocations, underlying bony pathology, or other conditions requiring immediate surgical or medical treatment.
5. Chiropractic treatment to the articulations of the extremities is not acceptable in respect of:
  - (a) fractures, dislocations, underlying bony pathology or other conditions requiring immediate surgical or other medical treatment;
  - (b) soft tissue injuries, including muscle contusions, hematomas, infectious conditions, tenosynovitis, tendinitis, bursitis, epicondylitis, carpal tunnel syndrome and Dupuytren's contracture, but excluding minor sprains and strains arising from an articular injury.
6. Prior to refusing or terminating authorization for chiropractic treatment, the Board Medical Advisor will be consulted and, in appropriate cases, the Board's Chiropractic Consultant.
7. A chiropractor who has been treating a worker will be notified of any decision by the Board to terminate its authorization for that treatment under the terms of this decision.

#### *#74.23 Examination by the Board*

The Board may call a worker in for a medical examination at any time. (9) Where there is no appreciable improvement during treatment, the chiropractor may ask the Board to call the worker in for examination.

When a worker who has been treated by a chiropractor has been examined at the Board and referred by a Board Medical Advisor to a medical consultant, the chiropractor must be notified by letter.

#### *#74.24 Consultation with Another Chiropractor*

On a problem case, a chiropractor may ask for consultation with another chiropractor. This may be allowed, but it must be authorized by a Board Medical Advisor. The responsibility for obtaining permission rests equally on the attending chiropractor and the consultant before the consultation is carried out, otherwise, the consultation fee may not be allowed. (10)

### *#74.25 Physiotherapy*

Physiotherapy cannot be prescribed by a chiropractor at the Board's Rehabilitation Centre or elsewhere.

Concurrent treatment is discussed in #74.60.

### *#74.26 Belts and Back Supports*

The supplying of belts and back supports cannot be granted on the order of a chiropractor, but may be approved by a Board Medical Advisor. (11)

### *#74.27 X-rays*

X-rays may be taken for the purpose of assisting a chiropractor in the treatment of a worker, subject to the following:

1. The Board will not pay for full-length views of the spine.
2. With respect to x-rays of the affected anatomical areas of the spine, the minimum examination should be as follows:
  - (a) Cervical spine – A.P. and lateral as well as an open-mouth view of the odontoid. Oblique views to be added as indicated.
  - (b) Dorsal spine – A.P. and lateral full-length views with additional coned views of areas not clearly shown on the two primary views.
  - (c) Lumbar spine – A.P., lateral, and a coned lateral view of the lumbosacral junction (oblique views to be taken in addition, if indicated).

Payment will not be made for x-rays of non-interpretable quality, for x-rays of areas of the body not injured, and for excess, or duplication of, x-rays.

Complete x-ray reports, signed by the chiropractor, must be submitted within seven days. The x-rays should be available to the Board on request.

### **#74.30 Dentists**

The Health Care Benefits Department accepts responsibility for dental repair for damage caused by compensable personal injury or occupational disease. Payments are based on the fee schedule approved by the Board. Prior to commencing the work, a practitioner should submit an estimate to the Board outlining the proposed treatment. Appropriate authorization will then be given to the practitioner.

Where there are two equally functional treatment plans, the Board authorizes the plan that is expected to be the least costly in the long term. If a worker declines the treatment plan authorized by the Board and proceeds on another treatment plan, the coverage will not exceed the amount of payment that would have been made for the authorized treatment plan.

Where a claim is submitted for work-caused damage to dentures, the claim is adjudicated under Section 21(8)(b) of the Act rather than Section 5 or 6 of the Act. This imposes different requirements for coverage. Further details are contained in #23.00 to #23.70.

Claims for damage to crowns and fixed bridgework are adjudicated as personal injury under Section 5(1) (see #13.00) rather than Section 21(8)(b) of the Act as crowns and fixed bridgework are regarded as part of the natural anatomy.

#### **#74.40 Naturopathic Physicians**

After eight weeks of treatment by a naturopath, or earlier if there is any ground for suspecting that the claimant is not receiving proper treatment, the worker's claim must be referred to a Board Medical Advisor. The Board Medical Advisor may take any of the courses set out in #74.21.

The Board will not pay for house visits after initial treatment, unless the necessity is clearly indicated.

Fees may be paid for simple laboratory procedures such as hemoglobin, erythrocyte sedimentation rate and urinalysis. The Board may also accept fees from a medical laboratory for tests related to the condition under treatment incurred on the worker's behalf.

The Board may accept the costs of normal services from radiologists who provide this service on behalf of injured workers to naturopaths.

The Board may call a worker in for examination at any time. Where there is no appreciable improvement during treatment, the naturopathic physician may ask the Board to call the worker in for examination. (12)

#### **#74.50 Selection of Physician or Qualified Practitioner**

Section 21(7) of the Act provides that "Without limiting the power of the board... to supervise and provide for the furnishing of health care in every case where it considers the exercise of that power is expedient, the board must permit health care to be administered, so far as the selection of a physician or qualified practitioner is concerned, by the physician or qualified practitioner who may be selected or employed by the injured worker."

Subject to the Board's overriding supervisory power, this provision entitles the claimant to select his or her own practitioner. It should be noted that:

1. The section makes no distinction between the original selection and the changing of a practitioner.
2. The section makes no distinction between a practitioner qualified under the *Medical Practitioners Act* and one qualified under the *Podiatrists Act*, the *Chiropractors Act*, the *Dentists Act* or the *Naturopaths Act*, provided that the practitioner accepts Board patients and the appropriate fee schedule.

In certain situations, the Board may object to the selection made by the claimant, and may object to a change of practitioner. For example, the Board may be likely to object if it appears that the claimant is shopping around to find the practitioner who is thought likely to write the most favourable report. On the other hand, the Board will not object, either to an original selection or to a change, simply on the ground that it does not think the claimant is making the wisest choice, or because the claimant's judgment in the selection differs from the judgment that the Board would itself have made.

Where a worker wishes to make a change of physician or qualified practitioner, the following guidelines apply:

1. Where a worker moves, a new physician or qualified practitioner may be selected in the new community without prior permission from the Board.
2. Where a worker receives emergency treatment from a physician who is not the family physician, the worker may transfer to the family physician.
3. A worker may wish to transfer because of a loss of rapport with his or her attending physician, or because of a preference for a type of treatment available from a different type of practitioner. Where it comes to the attention of the Adjudicator that a worker has made or plans to make a change of this kind, the matter will be referred to a Board Medical Advisor. The change will be permitted unless the Board Medical Advisor concludes that it is likely to be harmful, or so medically unsound that it ought to be prohibited.
4. Where it appears that the worker is shopping around for a most favourable medical report, the matter should be referred to a Board Medical Advisor to consider whether an examination at the Board would be appropriate.

5. If it appears that a worker is making multiple changes of physician or qualified practitioner, the matter will be referred to a Board Medical Advisor to consider whether a rational treatment program is being followed.

If the Board Medical Advisor, or Rehabilitation Centre Physician concludes that a change of physician or qualified practitioner should be refused, the decision must be communicated to all physicians and qualified practitioners concerned, as well as to the worker. The physician or qualified practitioner to whom the refusal relates will be notified that the Board will honour an account for treatment up until the date of the advice, but will not accept responsibility for treatment beyond that date.

Any decision to refuse or terminate treatment by a "qualified practitioner" is not legally defensible if it rests on the general objection to the treatment of any patient by that kind of practitioner. Any decision not to allow a claimant the "qualified practitioner" of choice must be justified by a judgment made in the particular case that the selection would be medically unsound by reason of circumstances relating to that particular case.

A Board Medical Advisor or Rehabilitation Centre Physician may arrange for the claimant to be referred to a specialist, however, the worker is not forced to accept treatment he or she does not wish to receive nor treatment from a doctor against whom the worker has some objection.

A claimant cannot attend a doctor whose right to render health care has been cancelled or suspended under the provisions referred to in #95.30.

#### **#74.60 Concurrent Treatment**

The general view of the Board is that a worker should be under treatment by only one physician or other qualified practitioner at a time.

There are cases, however, where concurrent treatment may be deemed acceptable. For example, the same disability may require treatment by a general practitioner and a specialist, by two or more specialists, or the worker may benefit from treatment by a qualified practitioner with concurrent monitoring by the attending physician.

Where reports indicate a worker is receiving concurrent treatment, the claim will be referred to a Board Medical Advisor or Rehabilitation Centre Physician for review. Where the Board Medical Advisor or Rehabilitation Centre Physician conclude concurrent treatment is reasonable, approval will be granted.

Concurrent treatment will not be refused by the Board simply because it is inconsistent with a rule or policy of a professional organization.

If approval for concurrent treatment is denied, in those cases where medical reports have been submitted within a reasonable time, corresponding health care benefit accounts will be paid to the date of the written notification.

## **#75.00 HEALTH CARE RENDERED BY PERSONS OTHER THAN PHYSICIANS OR QUALIFIED PRACTITIONERS**

Persons other than physicians or qualified practitioners may be authorized to render health care, for example, optometrists, dental mechanics, nurses and physiotherapists.

### **#75.10 Physiotherapists**

Physiotherapists, who are members in good standing of the Canadian Physiotherapy Association or the British Columbia Association of Physiotherapists in Private Practice, may provide injured workers the specific types of treatment they are authorized by statute to render.

#### *#75.11 Physiotherapy at the Boards Rehabilitation Centre*

The Board may admit workers to the Rehabilitation Centre prior to the initial adjudication of their claims. (13) In third party claims however, a worker has no right to compensation until the worker elects to claim compensation. (14) In such cases the injured worker will not be admitted to the Rehabilitation Centre for treatment until he or she has so elected.

In cases when a request is received for admission to the Rehabilitation Centre for treatment where wage-loss benefits and/or health care benefits have previously been terminated, the decision regarding reopening must be made before admission is allowed.

In order to control absenteeism at the Rehabilitation Centre, the following policy based on Section 57(2) of the *Workers Compensation Act* has been adopted:

1. Each claimant on the original admission to the Rehabilitation Centre will be provided with a copy of notice summarizing this policy.
2. A notice to like effect will be posted on notice boards throughout the Rehabilitation Centre and Residence.
3. All absences, where known in advance, must have the prior approval of the Adjudicator before wage-loss payment may be made.
4. All absences resulting from sickness must be supported by a doctor's certificate before wage-loss payment may be made.

5. Adjudicators will have the discretion to authorize the payment of wage loss for an absence where no prior approval has been obtained or no doctor's certificate has been produced, but where, however, the special circumstances of the case support the maintenance of wage-loss payments.
6. Adjudicators must approve requests by claimants to be excused treatment during the course of a day. If the interruption of treatment is for medical reasons, the advice of a Rehabilitation Centre Physician or Rehabilitation Centre Nurse should be obtained by the Adjudicator before permission is granted.
7. All claimants returning from an absence due to an illness must be examined by either a Rehabilitation Centre Physician or Rehabilitation Centre Nurse prior to resuming their treatment program.

#### *#75.12 Physiotherapy Given Privately*

The following policy guidelines now apply for all Workers' Compensation Board claimants with the exception of paraplegics and quadriplegics.

1. Physiotherapy prescribed by the attending physician may be continued up to a maximum of **eight weeks** per case.
2. Such physiotherapy treatment shall not exceed one treatment per day.
3. Such physiotherapy shall be rendered by a chartered or registered physiotherapist.
4. The attending physician and the physiotherapist are required to be in communication regarding treatment progress.
5. In cases where the attending physician considers that physiotherapy should continue beyond eight weeks, prior authorization must be obtained from a Board Medical Advisor. This may be done by writing or telephoning the Board. At the time the authorization is given, the period of additional treatment will be specified (up to a maximum of eight weeks additional).
6. Where it is not feasible for the attending physician to obtain prior authorization, the request shall be submitted by the attending physiotherapist.
7. The physiotherapist may also communicate with the Board concerning patient progress. Such communication may be in the form of a letter or copies of progress reports sent to the physician.

8. Any case requiring physiotherapy treatment in excess of 16 weeks total accumulative amount shall be referred to the appropriate Board Medical Advisor/Consultant for consideration of approval to continue beyond this interval.

### **#75.20 Nurses**

For seriously ill or injured workers who need additional nursing service, the necessary nursing service is determined and provided by the hospital. The Board is not responsible for payment of special duty nursing fees. If the worker or the worker's family desire to have a special nurse in attendance, the cost of employing such special nursing should be met by the worker. If the condition requires additional nursing service, the physician should indicate to the hospital the service necessary and discuss with the hospital any question about these requirements as this matter is outside the jurisdiction of the Board.

Temporary home nursing care is covered where it is specifically required because of the nature of the compensable medical condition. Where care is required permanently, the costs are covered under a personal care allowance (see #80.00).

When a registered nurse is required as nursing escort during emergency transportation, Registered Nurses Association fees will be paid, as well as the nurse's expenses.

Reports received from Canadian Red Cross Society Outpost Hospital nurses can be accepted in lieu of medical reports if there is no physician in the immediate area.

### **#75.30 Dental Mechanics**

The fees paid to Dental Mechanics cover such necessary reports as the Board may require.

Reports submitted should state clearly the exact extent of dental damage occasioned by the accident, the method of restoration and the fee therefore itemized according to the schedule.

### **#75.40 Health Spas and Public Swimming Pools**

The costs of using spas, public swimming pools or other exercise programs that are not provided by a recognized health care professional are not recognized by the Board as a health care benefit cost.

## **#76.00 HOSPITALS AND OTHER INSTITUTIONS**

Only hospitalization that is directly necessary in the treatment of the worker's compensable injury may be paid by the Board.

### **#76.10 In-patient Treatment**

In-patient per diem rates paid to hospitals are inclusive of all costs associated with the hospitalization. Costs associated with special nurses (see #75.20), beds or any other equipment are covered by the per diem rate and are not paid for separately.

The Board covers the cost of a public ward bed. However, a Board officer may authorize a private or semi-private bed where it is cost effective in minimizing wage loss resulting from a delayed admission.

A private or semi-private room will also be authorized where the critical condition of the claimant requires it.

### **#76.20 Short Stay Patients**

Out-patient charges, including charges for emergency services, are covered by the Board where hospital services are necessary for the treatment. Where a physician chooses to see a patient in a hospital in lieu of an office visit, this is considered an arrangement between the doctor and the hospital. In such cases, only the doctor's physician services are paid for by the Board.

### **#76.30 Private Hospitals**

Private hospitals may be utilized for treatment of pre-operative or post-operative patients who require active nursing care. The Board's approval must be obtained before a patient is admitted to such a hospital. If a patient is admitted without such approval, no payment will be made for hospitalization.

The attending physician must report to the Board at regular intervals regarding the patient's condition and the necessity for continued hospitalization.

The Board's approval must be obtained for any absence from the hospital for any purpose other than medical treatment and examination. No payments will be made for hospitalization during such a period of absence unless Board approval has been obtained. Any cases of intoxication, other substance abuse, or misconduct must be reported immediately to the attending physician and the Board.

## **#76.40 Laboratory Procedures**

Board responsibility is limited to laboratory procedures required for diagnosis and treatment of conditions due to the compensable injury.

## **#76.50 Application of Compensation to Worker's Maintenance in Hospital**

This is discussed in #49.10.

## **#77.00 DRUGS, APPLIANCES, AND OTHER SUPPLIES**

In addition to medical examination and treatment, the Act provides for necessary health care benefits in the form of drugs, appliances, and other supplies.

### **#77.10 General Position**

Accounts for medicine, bandages, and other supplies are payable only when they are prescribed by the attending physician and where medical reports to the Board verify their necessity.

Medicine, bandages and other items provided during an in-patient hospital stay are covered by the inclusive per diem rate. If, however, a claimant is provided an appliance or material for use after discharge, a separate charge is made by the hospital to the Board. This coverage is in lieu of the claimant being required to make the purchase from a medical supply house, such as a pharmacy, following discharge.

The Board may furnish appliances:

1. of a temporary nature to aid in the worker's recovery. The appliance is supplied as a temporary measure only and may not be replaced without the authorization of the Board;
2. of a permanent type when there is a permanent disability. Such an appliance is kept in repair and replaced as required.

Requests for repair or replacement of an appliance will usually be accepted without question when the repair or replacement is such as is reasonable to expect will result from normal wear and tear. This will normally be determined from the Board's experience as to the normal maintenance requirements and normal lifespan of the item in question. When a requested repair or replacement is not, on the face of it, such as is reasonable to expect from normal wear and

tear, investigation will be made as to the actual cause of the request. In general, this means that, on the one hand, responsibility will be accepted if the loss or damage is due to the wear and tear or an accident arising in the claimant's particular style of life. On the other hand, responsibility will be declined if the loss or damage resulted from deliberate or reckless abuse or has occurred with excessive frequency.

The repair and replacement of appliances broken or damaged at work is discussed in #23.00.

## **#77.20 Types of Supplies and Appliances**

Set out below are some of the supplies and appliances provided by the Board and the conditions under which they are provided.

The list is not all inclusive. A claimant or the treating practitioner may contact the Health Care Benefits Department to determine if a particular item will be covered.

### **#77.21 Eyeglasses**

Where eyeglasses are required because of an injury, the necessary corrective glasses are provided as required, as are artificial eyes. In all cases, hardened lenses are provided. Dark glasses may be supplied if prescribed by the attending physician or specialist as necessary. Frames are also supplied if damaged or not previously utilized.

Contact lenses may be provided at Board rates if the Board Medical Advisor considers they would improve the vision of, for example, an aphakic eye or scarred cornea.

Where an injury results in serious impairment to a worker's sight, the Board may, to protect remaining vision, provide protective eyeglasses. (15) Therefore, if a worker loses the sight or a substantial part of the sight of an eye in an industrial injury, glasses with hardened lenses are provided to protect the remaining sight.

The policy regarding repair or replacement is the same as outlined in #77.10.

### **#77.22 Hearing Aids**

The provision of a hearing aid by the Board is not subject to any fixed monetary ceiling but is generally based on a negotiated fee schedule.

Where a claimant is adjudged entitled to health care benefits for loss of hearing, the Board will provide such hearing aid as is reasonable and necessary to achieve optimum satisfaction for the claimant.

The decision will be made by the Adjudicator generally after receiving medical advice and, if appropriate, input from an Occupational Hygiene Officer.

Where a claimant prefers a binaural hearing aid, this will be provided by the Board if it is expected to meet her or his needs, and it will be provided whether the preference is based on performance expectations or is purely aesthetic.

Claimants are advised not to make a private purchase of a hearing aid. Any such private purchase made will be at the claimant's own expense.

A telephone amplifier may be provided for hearing-loss claimants in cases where it is deemed appropriate.

### *#77.23 Artificial Limbs*

Where an injury results in the loss of a hand, foot, arm, or leg, artificial limbs are supplied and kept in repair and replaced as needed. Wherever possible, prosthetic and orthotic supplies should only be requisitioned from facilities which have registered prosthetists and orthotists on their staff.

In all cases of major amputations, early referral to the Board's Rehabilitation Centre in Richmond is desirable (if there are no complications, as soon as the suture line has healed). A prosthesis will be supplied while at the Rehabilitation Centre, where ample time will be allowed for training in its use and for necessary adjustments while under observation.

Workers receiving artificial limbs are also entitled to the clothing allowance referred to in #79.00.

### *#77.24 Crutches, Canes, and Wheelchairs*

Crutches or canes are covered where required as a result of the compensable condition.

Wheelchairs are issued to those claimants who are permanently disabled and unable to walk. A wheelchair may be replaced when no longer serviceable, but necessary repairs may be authorized periodically during the life of the chair.

### *#77.25 Boots and Shoes*

Special footwear will be provided when:

1. there is a permanent deformity of the foot as a result of a compensable injury and standard footwear cannot be adequately adapted;

2. special footwear is required during rehabilitation or treatment for a temporary disability. This may include outside shoes required as a temporary measure.

Alterations to a worker's own boots and shoes, such as metatarsal bars, heel and sole raises, and arch supports, will be provided as a temporary measure, or on a permanent basis where necessary. The Board may request to examine footwear.

Where a claimant is receiving physiotherapy from a private clinic and it is necessary to purchase running shoes, the Board will reimburse the cost up to \$25.00.

#### *#77.26 Belts and Braces*

Should the claimant's injury necessitate the wearing of a back belt, spinal or leg braces, splints or elastic stockings, these are supplied. This may be on one occasion only to enable the patient to overcome the effects of the injury, or in the case of permanent disability, it would be kept in repair and replaced as required.

The clothing allowance referred to in #79.00 is payable to workers who have to wear a leg brace.

#### *#77.27 Home and Vehicle Modifications*

With respect to major home and vehicle modifications required due to serious disabilities, the Vocational Rehabilitation Consultant investigates the need for these modifications. Where the renovations or modifications are for vocational purposes, they are considered as a rehabilitation expense. (See #90.00.) Where they are necessary for normal daily living because of the compensable medical condition, they are considered a health care benefit expense.

Examples of home modifications are ramps, elevators, wheel-in showers, grab-bars, doorway widening and wing taps for sinks.

Examples of vehicle modifications are hand controls and van lifts.

Necessary maintenance of the home or vehicle modification where required for medical purposes is also covered.

#### *#77.28 Medical Supplies for Paraplegics and Quadriplegics*

The Board supplies paraplegics and quadriplegics with all necessary medical supplies pertaining to their disability. These are obtained by contacting the Board's Health Care Benefits Department.

Where necessary, paraplegics and quadriplegics are provided with a range of medical equipment. Examples include hospital-type beds and mattresses, long leg braces, crutches, raised toilet seats, grab-bars, wheelchairs and commodes. The list includes the various items required to take care of bowel and bladder functions. Supplies also include condoms, tubing, darvol bags, suppositories and disposable gloves for example. Costs of water mattresses, waterbeds or alternating pressure pads are covered where needed to prevent skin breakdown or spasm.

#### *#77.29 Miscellaneous Items*

Generally, an item of equipment designed as a medical appliance (for example, a wheelchair) is acceptable as a health care benefit expense if it is medically required because of the compensable condition. Periodically, however, the Board receives requests to provide equipment not normally considered a medical appliance. Examples are hair-pieces, computers, televisions and specialized sports equipment. Unless the equipment is for the purpose of providing medical treatment for the compensable condition, or the individual is otherwise unable to carry out the normal functions of daily living and the equipment is designed for those reasons, it is not considered a health care benefit expense. In these circumstances, however, consideration may be given to providing such items as a rehabilitation expense.

#### **#77.30 THE PRESCRIPTION OF NARCOTICS AND OTHER DRUGS OF ADDICTION**

The following policy applies:

1. Board responsibility for narcotic analgesics, hypnotic-sedatives and tranquilizers (see examples in Table 1) will be limited to a post-injury or post-surgery period of eight weeks. An extension of this eight-week period may be considered, however, where there are special or extenuating circumstances; for example, where a worker has received, or will receive, a permanent disability pension and requires regular intermittent and limited narcotic preparation for the relief of pain.
2. If an Adjudicator or Payment Clerk continue to receive accounts for these drugs beyond the eight-week limit, the worker's claim will be referred by the Adjudicator to a Board Medical Advisor. The Board Medical Advisor will contact the attending physician by phone where possible, outline the details of this policy, and discuss any special or extenuating circumstances. The Board Medical Advisor will also discuss the use of acceptable therapeutic alternatives such as: N.S.A.I.D.'s, anti-depressives, T.N.S., biofeedback. If necessary, an

extension beyond eight weeks may be recommended by the Board Medical Advisor following this discussion.

3. The Board Medical Advisor's discussion and resulting recommendation will then be documented on the worker's claim file and referred to the Adjudicator.
4. The Adjudicator's decision will be communicated in writing to the worker with a copy to the attending physician.

### **Table 1**

#### **1. Analgesic Target Drugs**

- (a) Analgesic combinations containing 50 mg or more of Codeine
- (b) Pentazocine and combinations (Talwin®, Talwin Compound 50®)
- (c) Oxycodone and combinations (Percodan®, Percocet®, etc.)
- (d) Propoxyphene and combinations (Darvon N®, 642®, 692®, etc.)
- (e) Meperidine (oral) (Demerol®)
- (f) Barbiturate + A.S.A. + Codeine combinations (Fiorinal®, Anadol®, Phenaphen®)
- (g) Anileridine (Leritine)
- (h) Morphine and M.S. Contin and M.O.S.
- (i) Hydromorphone (Dilaudid)

#### **2. Sedative-Hypnotic Drugs**

- (a) Barbiturates
- (b) Meprobamate

#### **3. Tranquilizers**

- (a) Diazepam
- (b) Chlordiazepoxide

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

**APPLICATION:** Applies on or after October 1, 2007

## **#78.00 DIRECTION, SUPERVISION, AND CONTROL OF HEALTH CARE**

Health care furnished or provided shall at all times be subject to the direction, supervision, and control of the Board. (16)

It will be noticed that health care “is subject to” the direction, etc., not “under” the direction, etc. The Board has a choice, therefore, about the circumstances in which it will give direction.

### **#78.10 Direction, Supervision, and Control of Treatment**

All questions as to the necessity, character, and sufficiency of health care to be furnished shall be determined by the Board. (17)

A main purpose of the control of treatment by the Board is to ensure that treatment is not overlooked, and that treatment choices are not overlooked. Much of the work takes the form not of “direction” or “control” but rather suggestions and advice to the attending physician. Insofar as the Board does exercise control, it relates largely to the approval or disapproval of payment for elective surgery. Sometimes, however, it may relate to other matters, such as a direction that the patient be examined by a specialist, or that a particular institution be attended rather than another.

The Board uses its control over treatment to promote recovery, and to exclude choices by patients or doctors that will delay recovery, or create an unwarranted risk of further injury. But the control of treatment by the Board is not intended to exclude patient choices. If there are reasonable choices of treatment, or reasonable differences of opinion among the medical profession with regard to the preferable treatment, or choices to be made that depend on personal preferences, the matter should be regarded as one of patient choice.

Where a treatment or appliance is deemed reasonably necessary and more than one type is suitable, the choice is left to the treating practitioner and the worker. Where, however, the selection of a treatment or appliance will likely result in a significant increase in the length of disability, the Board will normally authorize the treatment or appliance that is the most likely to enable the worker to return to work at an early date. If there is a substantial difference in costs of equally effective treatments or appliances, the Board will authorize the less costly. In such cases, if the worker chooses the more costly option, the Board will cover costs up to the amount that would have been paid for the less costly, but equally effective, option.

Where coverage for a non-standard treatment program, medical appliance or other health care benefit expense is contemplated, prior approval of the Board is

suggested. Either the health care professional or the worker may request this. Failure to do so may result in expenses being incurred that will not be covered by the Board.

Whether the treatment for a disability is an appropriate treatment for approval by the Board is a matter for decision by a Board Medical Advisor.

### *#78.11 Authorization of Elective Surgery*

Authorization must be obtained from the Board before carrying out any elective procedures. Authority may be obtained by telephone, FAX, or letter. The Board does not expect the practitioner working under emergency conditions to obtain prior authorization before performing necessary procedures.

A particular surgical treatment will not be refused simply on the ground of a personal preference for an alternative course of action; but it will be refused if it is felt unduly hazardous, having regard to its potential benefits and the risks involved in not having the surgery, or unlikely to promote recovery, or totally unnecessary, or if it would seem reasonable to try less drastic measures first.

The conclusion of the Board Medical Advisor on an application for approval of elective surgery is not limited to approval or disapproval. It may include taking any other steps that the Board Medical Advisor considers would be sound medical practice. For example, if it should appear that the attending physician or the patient is expecting the operation to result in total recovery when it normally results in only limited improvement, the Board Medical Advisor may conclude that the operation should be approved, but that the matter should be discussed further with the treating doctor to try to ensure that the patient is informed of the likely results.

Where there is doubt about the existence of a disability, it is possible for the diagnosis of a Board Medical Advisor for treatment purposes to differ from the conclusions reached by the Claims Adjudicator for claims purposes. In other words, it is a legal and logical possibility for the Board to conclude that a claimant should be classified as a person having a particular disability for the purposes of compensation payments, but classified as a person not having that disability for the purposes of a particular remedial treatment. Suppose, for example, the claim is one for an internal disorder. Medical opinion is uncertain, but indicates about an equal probability that the claimant has this disorder. Applying the terms of Section 99 to the medical evidence, the correct conclusion, for claims adjudication purposes, may well be that the claimant has a disorder, and is entitled to compensation. But if the attending physician is seeking approval of a high risk operation, then, depending on the other variables, the Board Medical Advisor might decide that the surgery should be refused on the grounds that the probability that the claimant is suffering from that disorder is not sufficiently high to warrant the risks of that particular treatment.

In cases where authorization for treatment is not granted, the worker should be made aware of this decision in writing by the Adjudicator with a copy to the attending physician and specialist. The Claims Adjudicator must have this letter reviewed by the Medical Advisor to ensure the medical content is correct. An explanation of the decision should be given so that the worker can make informed decisions about the treatment or its relationship to the injury. The Board Medical Advisor will, except in rare circumstances, discuss this decision in advance with the treating physician or specialist.

If a worker acted reasonably in undergoing unauthorized treatment, compensation will be paid to him or her for the consequences of that treatment. The claim of the attending physician or specialist for payment of the cost of the treatment is, however, determinable by different criteria. The Board may not meet the cost of treatment after authorization for it has been refused. (18) This would depend largely on the degree to which the doctor was aware of the Board's position.

#### *#78.12 Worker Engages in Insanitary or Injurious Practices*

Section 57(2) provides in part that "The board may reduce or suspend compensation when the worker

- (a) persists in insanitary or injurious practices which tend to imperil or retard his or her recovery; . . ."

The following principles are observed in applying this provision:

1. The worker must be made aware that the practice is deemed insanitary or injurious, that it must be discontinued, and that benefits will be reduced or suspended if she or he persists in the practice after that warning.
2. It will not be necessary in all cases for the Board officer imposing the suspension to do so only after securing medical advice to the effect that the practice is indeed insanitary or injurious. To take an extreme example, should an Adjudicator observe a claimant with a broken leg in a cast attempting to remove the cast because it is uncomfortable, it will be obvious to the Adjudicator, although a layperson, that the practice is not conducive to recovery and should be discontinued. On the other hand, in any situation where there is any room for doubt about the insanitary or injurious nature of the practice, it will be necessary for the Adjudicator to seek some medical advice before warning the claimant against a continuation of the practice.
3. Should the practice come to the attention of a Board Medical Advisor in the course of an examination, the claimant should be advised that the practice will retard recovery or tend to lead to further injury and

should be discontinued, and that the Adjudicator will be so advised of this opinion. It will then be the responsibility of the Adjudicator to formally advise the claimant that persisting in the practice will result in reduction or suspension of benefits.

4. Once benefits have been reduced or suspended, the claimant will be advised that an assurance, acceptable to the Adjudicator, that the insanitary or injurious practice will not be repeated, will be sufficient for resumption of full benefits. Of course, should the claimant persist in the practice after such assurance is given, benefits will once again be reduced or suspended forthwith and any further assurances will be received with considerable skepticism.

Section 57(2)(a) has no application where it is discovered after the fact that a claimant has engaged in an insanitary or injurious activity, but that activity has now ceased. The section is intended as an inducement by workers to take more care in promoting their own recovery and, therefore, is only applicable where the activity in question is continuing. However, compensation may be denied without invoking this section if the insanitary or injurious conduct engaged in by a claimant shows that the claimant was not disabled during the period in question, or if the evidence indicates that the disability was due to this conduct rather than to the original work injury.

#### *#78.13 Worker Refuses to Submit to Medical Treatment*

A claimant will not be forced to accept treatment the claimant does not wish to receive nor treatment from a doctor against whom he or she has objection.

However, Section 57(2) provides that "The board may reduce or suspend compensation when the worker

- (a) . . .
- (b) refuses to submit to medical or surgical treatment which the board considers, based on expert medical or surgical advice, is reasonably essential to promote his or her recovery."

The term "medical treatment" in this subsection is not limited to treatment performed by doctors. It includes, for example, therapy by paramedical personnel.

Decisions on whether compensation should be reduced or suspended under this subsection are made by the Adjudicator; but there must be an input of medical advice. Where a Rehabilitation Consultant is working on the case, he or she must also be consulted.

Under Subsection 2(b), there must be a clear medical opinion on file that the relevant treatment "is reasonably essential to promote his recovery". There must

be evidence that the worker has been offered that treatment and knows that it is considered by the Board reasonably essential to promote recovery. There must be evidence that the worker was in a position to make a choice, and refused the treatment. Also, the worker must be given a chance to explain before any decision is made.

Subsection 2(b) is not intended to exclude all patient choices, and even when the terms of the subsection are satisfied, the Adjudicator is not bound to reduce or suspend compensation benefits in every case. There is a discretion. For example, if the proposed treatment involves a significant risk of an adverse side-effect, or a questionable prospect of success, or is hazardous, the Adjudicator might well conclude that the refusal to undertake that treatment was reasonable.

#### *#78.14 Acupuncture*

The Board does not generally accept responsibility for acupuncture. Any exception must be previously authorized. Even where an exception is allowed it is usually only for a short period of time and then only in conjunction with an overall program for dealing permanently with the claimant's problem such as is found at a pain clinic. The Board would not likely authorize the treatment where it was being carried out on a routine long-term basis. Where approval of acupuncture treatment is granted, the number of treatments allowed and the fees payable will be set. Requests for authorization of acupuncture treatment are initially referred by the Adjudicator to the Unit or Area Office Medical Advisor. Where this Board doctor feels that treatment approval should be considered, the claim is referred to the Vice-President, Medical Services Division for a decision. The request should provide details such as the number of treatments, the cost and the expected benefits. Treatments that do not meet the above general criteria are usually denied at the unit or area office level.

#### **#78.20 Examinations and Consultations**

Section 57(1) provides as follows:

“The board may require a worker who applies for or is in receipt of compensation . . . to be medically examined at a place reasonably convenient for the worker. If the worker fails to attend for the examination or obstructs the medical examiner, the worker's right to compensation is suspended until the examination has taken place, and no compensation is payable during the period of suspension.”

The examination may be by the worker's own attending physician, a Board Medical Advisor/Consultant or an outside consultant. The worker will be notified in advance of the type of doctor or practitioner who will do the examination.

### *#78.21 Examination at the Board*

A Board Medical Advisor does not arrange to examine a worker on his or her own initiative. If a request is received from an attending physician the Adjudicator is consulted before an examination is arranged.

In all cases, the attending physician will be notified by letter of the intention to bring the worker to the Board for an examination (or consultation with a specialist).

The attending physician will be notified by the Adjudicator of any claims decision following the examination, and any changes in the status of the claim, unless matters of internal administration only are involved. The Board Medical Advisor is responsible for notifying the attending physician of any medical matters that should be brought to the physician's attention following the examination.

### *#78.22 Consultation with Specialists*

In an accepted claim where treatment is continuing and no transportation costs for the worker are involved, no permission of the Board for a consultation is necessary. No consultation shall be charged to the Board unless the necessity for consultation in respect of the injured part has been shown on the referring doctor's reports.

Where transportation costs for the worker are involved, permission for the referral of a worker for consultation must be obtained from the Board.

Where the Board arranges a consultation with a specialist, the attending physician must be notified of the appointment. Where a Board Medical Advisor wishes to refer a worker to a consultant, it will, if practicable, first be discussed with the attending physician giving him or her an opportunity to express a preference as to the consultant.

When a consultation is authorized on an investigative basis for an opinion necessary for the adjudication or possible reopening of a claim, arrangements may be made for the examination of the worker at the Board prior to being seen by the specialist. This is at the discretion of the Board Medical Advisor. Where the validity of the claim has not yet been determined, it will be indicated to the specialist that no treatment or compensation benefits can be authorized until the decision has been made on the claim.

Board policy does not permit approval of surgery on an investigative basis. Investigative referrals for consultation or examination do not extend to invasive procedures that could result in a disability. Where surgery is being requested, and it is not felt the condition is a Board responsibility, the worker is advised that such surgery must be undertaken on a private-patient basis. The worker is also

advised that the Board will be prepared to review the surgical report to determine whether any Board responsibility does exist.

When the opinion of a consultant is being sought, the Adjudicator and the Board Medical Advisor are required to detail exactly the relevant medical questions which must be specifically addressed by the consultant. The instructions to the consultant are in writing.

When a worker has been referred to a specialist at the request of the attending physician with reference to diagnosis or treatment, a copy of the specialist's report will be sent to the attending physician by the specialist or the Board Medical Advisor. Similarly, when the worker is referred by a Board Medical Advisor to a specialist with reference to diagnosis or treatment, a copy of the specialist's report will be sent to the attending physician.

Decisions taken with regard to appropriate action upon receipt of the consultant's report will be the responsibility of the Board Medical Advisor with respect to treatment issues, and the responsibility of the Adjudicator with respect to adjudication issues.

#### *#78.23 Psychiatric Treatment and Consultation*

Where a psychiatric examination is being arranged, it will, in most cases, be on an investigative basis. Psychiatric treatment will not normally be authorized until a report has been received from the psychiatrist relating to diagnosis, etiology, treatment possibilities and prognosis.

#### *#78.24 Failure to Attend, or Obstruction of, Examination*

Before compensation can be suspended under Section 57(1) on the grounds of a failure to attend, or obstruction of, a medical examination, the following prerequisites must be satisfied:

1. There must be clear evidence that an appointment was made and that the date, time and place were communicated to the worker and that the worker did not advise, by letter or otherwise, that the arrangements for the examination were not convenient.
2. There must be clear evidence of obstruction.
3. The worker must be advised by the physician, in general terms, of the provisions of Section 57 and that the obstructive behaviour will be reported to the Adjudicator.

4. Should the worker persist in refusing to be examined or in obstructing the examination, the attempt shall be concluded and the matter referred forthwith to the Adjudicator.
5. The Adjudicator must advise the worker, in person, by telephone, or in writing, of the intention to apply Section 57(1), reasons for the intended action, and the worker must be given an opportunity to explain the refusal or obstruction.
6. Should an explanation not be forthcoming, or should it be deemed unsatisfactory by the Adjudicator, payment of benefits shall be suspended.
7. Should the worker not appear for the examination, the steps outlined in (5) and (6) above shall be undertaken.
8. Notice to the claimant of the suspension of benefits shall include notice of an appointment for a further examination and should advise that, should the worker attend and be examined on that occasion, benefits will be reinstated, however, without retroactivity.

Where a pension is instituted, the retroactive date of the pension should not automatically be the day following the date of wage-loss suspension. The effective date of the pension must be the date when it is deemed the worker's condition has stabilized.

### **#78.30 Fees or Remuneration**

The Board may contract with physicians, nurses, or other persons authorized to treat human ailments, hospitals, and other institutions for any health care required, and to agree on a scale of fees or remuneration for that health care. (19)

The fees of health care professionals are normally governed by fee schedules approved by the Board. These may be fees negotiated specifically by the Board or the Board may have decided to adopt the fee schedule of another agency such as the Medical Services Commission. Where there is not an approved fee schedule, the treatment and the fees payable must be approved in advance by the Board.

The fees or remuneration for health care furnished shall not be more than would be properly and reasonably charged the worker if personally paying, and the amount shall be fixed and determined by the Board, and no action for an amount larger than that fixed by the Board shall lie in respect of health care benefits. (20) The doctor is not permitted to bill the worker for any balance of the account regarding a compensable condition which the Board has not agreed to pay. If

the doctor does this, the Board reimburses the claimant, but deducts the amount from any future account the doctor submits to the Board.

Information regarding the current fee schedules of the Board for the professions and other suppliers of goods and services can be obtained by applying to the Board.

### *#78.31 Adjudication of Health Care Benefits Accounts*

All accounts submitted to the Board for services and goods provided for injured workers are audited by the Health Care Benefits Department of the Board to ensure compliance with the Act and the fee schedules, and to ensure that the services or goods are appropriate to the worker's condition.

Where it is determined that services or goods supplied to a claimant are not related to a compensable condition, the supplier will be notified as soon as possible.

When a decision is made by a Board officer that a worker's ongoing problems are not considered compensable, this decision is conveyed in writing to all concerned, including individuals or facilities that submit treatment accounts. Regardless of the timing of the decision letter and the receipt of accounts, no accounts are payable for treatments after the date the worker is no longer deemed to be suffering from a compensable condition.

For a variety of reasons, the Board may decide to limit medical treatment even though the worker's ongoing complaints are considered to be compensable; for example, a denial of concurrent treatment (#74.60) or a denial of an extension of chiropractic treatment (#74.21) or physiotherapy (#75.12). When such limitations occur, the Board normally will pay accounts up to the date of the decision letter if the reports or accounts are submitted promptly and in good faith. If the practitioner, however, neglects to inform the Board of the treatment until some time after it is provided and by so doing delays the Board's decision, these accounts will not be paid.

All accounts should be submitted promptly at the conclusion of the transaction or treatment. Section 56(3) provides that "Unless the board otherwise directs, an account for medical services or health care must not be paid if it is submitted later than 90 days from the date that

- (a) the last treatment was given; or
- (b) the physician or person furnishing the medical service was first aware that the board may be liable for his or her services, whichever first occurs."

In applying this section, some degree of discretion is exercised. The general policy is that if a person has provided a medical service it should be paid for.

However, serious offenders may be notified of this requirement. If they continue their practice of late billing, their accounts may be rejected.

*#78.32 Reversal of Decision on Review or Appeal*

Where a claim, previously allowed, has now been disallowed, the Board will not initiate any steps to recover health care benefit payments already made; but if the Board is offered reimbursement by any other agency, the offer will be accepted.

Where accounts are outstanding at the time when the disallow decision is made, or are received after the decision, those accounts will not be paid, and the people rendering the accounts will be advised to submit them elsewhere. In these circumstances, the Board only declines to pay accounts for treatment, etc. Fees for reporting to the Board are still payable; so are the fees for any examination of the patient undertaken at the request of the Board for adjudication purposes.

Where a claim, previously disallowed, is now allowed, the Board will not at its own initiative solicit accounts for health care rendered prior to the date when the claim is allowed; but if accounts are received in respect of health care already rendered in respect of the compensable injury, and the Review Division or the Workers' Compensation Appeal Tribunal decision does not deal with the question of entitlement to that health care, the accounts are adjudicated as if the claim had been accepted in the first instance. The Board officer has, however, a discretion to pay for medical treatment or procedures undergone by the worker in good faith on the advice of his or her practitioner, even though the treatment or procedures might not ordinarily be approved for the worker's condition. The Board will not, under this policy, pay for treatment modalities or diagnostic procedures not generally recognized by the Board.

A copy of the Review Division or Workers' Compensation Appeal Tribunal decision reversing the previous decision is sent to the attending physician.

**EFFECTIVE DATE:** March 3, 2003 (as to references to the Review Division and The Workers' Compensation Appeal Tribunal)

**APPLICATION:** Not applicable.

*#78.33 Form Fees*

Where a claim is disallowed or suspended, and accounts submitted for treatment are not being paid, a form fee is paid in respect to any medical reports submitted prior to the date of the decision to disallow or suspend the claim.

Where a claim is rejected, that is, where:

1. a self-employed worker has no personal optional protection; or

2. the claimant was employed by an employer not covered under the Act;  
or
3. a report was submitted in error;

form fees are not normally payable. In the event of the unusual situation where a medical report had been requested by the Board and the claim is eventually rejected, the form fee will be paid.

## **#79.00 CLOTHING ALLOWANCES**

The clothing allowances set out below are payable to upper and lower limb amputees wearing prostheses, and to workers wearing a leg brace. (21) The amputation must be at or above the wrist, or at or above the ankle. Effective July 1, 1993, the allowance is also payable to a worker confined to a wheelchair, who is not otherwise entitled, at the same rate as is payable to a lower limb amputee.

	<b>Single Upper Limb Amputee</b>	<b>Bilateral Upper Limb Amputee</b>	<b>Lower Limb Amputee or Requires a Leg Brace</b>	<b>Upper and Lower Limb Amputee</b>
July 1, 1998 - June 30, 1999	\$236.89	\$474.93	\$474.93	\$711.88
July 1, 1999 - June 30, 2000	240.83	482.82	482.82	723.71
July 1, 2000 - June 30, 2001	245.86	492.91	492.91	738.83
July 1, 2001 - June 30, 2002	254.61	510.45	510.45	765.12

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

Effective January 1, 2008, the amounts of the clothing allowances will be adjusted on January 1 of each year. The Board determines the percentage change to be applied annually to these amounts by comparing the percentage change in the consumer price index for October of the previous year with the consumer price index for October of the year prior to the previous year.

Payment of the allowance is automatically made by virtue of the amputation. Proof is required neither of the wearing of the prosthesis or prostheses nor of the replacement, repair, or damage to clothing. Payment in the case of leg braces is contingent on the continued wearing of the apparatus.

Entitlement to this allowance commences as of the date of the amputation or the worker's commencing to use the brace or wheelchair. Payment is made by separate cheque on January 1<sup>st</sup> of each year. This is a full calendar year payment which covers the year of payment. The first payment is made on the January 1<sup>st</sup> following the initiation of pension payments and this first payment will include any retroactive entitlement for prior periods of disability not previously paid.

Payment of this clothing allowance is withheld while a worker is in prison. The amount withheld is paid to the worker on release if the period in prison was less than one year. If the period in prison is more than one year, the clothing allowance is not paid for each full year the worker was in prison.

**EFFECTIVE DATE:** October 1, 2007 – Revised to change the reference to the date of clothing allowance adjustments from July to January 1<sup>st</sup> of each year.

**APPLICATION:** Applies on or after October 1, 2007

## **#80.00 PERSONAL CARE EXPENSES OR ALLOWANCES**

In cases of major injuries, such as spinal cord injuries, resulting in paraplegia or quadriplegia, severe head injuries, hemiplegia, aphasia, near or total blindness, multiple amputations, or severe disability as a result of occupational diseases, the Board may pay certain personal care expenses. These expenses are in addition to wage-loss or pension benefits.

Personal care expenses may be paid when a seriously disabled person, though not confined to an institution, has very limited mobility or requires assistance in toilet functions, bathing, eating, or has other problems in caring for himself or herself, or needs assistance to a lesser or greater degree in daily living. Personal care expenses are payable at the discretion of the Board. An investigation is made of the circumstances of each case.

While aimed primarily at situations where there is severe permanent disability, in limited situations personal care expenses may also be paid in cases of severe temporary disability. Before making temporary payments, consideration is given to such factors as the worker's home and family situation, geographical location, the medical condition and other relevant difficulties.

In lieu of the actual personal care expenses incurred by the worker, the Board may pay a flat rate personal care allowance determined in accordance with the principles set out in #80.10 and #80.20 below.

The payment of personal care expenses or allowances will cease upon the death of the worker.

## #80.10 Levels of Personal Care Allowances

There are five levels of personal care allowances:

**Level 1:** The claimant has restricted mobility but can feed, partly cleanse and otherwise care for himself or herself but does need some assistance in acts of daily living.

Examples are:

Blindness or near blindness, multiple amputations at or above the wrist or ankle, aphasia, hemiplegia, or any permanent disability resulting in a loss of function of the limbs, but not to an extent that significantly impairs other body functions.

**Level 2:** Restricted mobility. Claimant can feed, clothe and wash himself or herself but needs assistance in other aspects of personal care and acts of daily living.

This includes:

Paraplegia with bowel and bladder functions impaired.

**Level 3:** Restricted mobility. Claimant needs ongoing assistance in washing, shaving, dressing, feeding, precautionary attention to skin care and ongoing assistance in daily living.

Examples are:

1. Severe head injury resulting in brain damage to the extent that the claimant is not bedridden, but is dependent upon assistance and ongoing care.
2. Quadriplegia with impairment of bowel and bladder functions.

**Level 4:** Claimant is almost totally immobile and requires extensive assistance in maintaining personal hygiene, precautionary attention to skin care and ongoing assistance in all phases of daily living.

Examples are:

High lesion quadriplegia or severe head injuries.

**Level 5:** The claimant is totally immobile for all practical purposes and essentially requires assistance in all phases of personal hygiene, body functions and acts of daily living (quadriplegic, decerebrate and bedridden).

The determination of whether a personal care allowance is applicable and the appropriate level may include consideration of factors such as home and family situation, geographic location and other difficulties that may be encountered in relating to the claimant's environment. Other medical conditions that may not be a direct result of the personal injury sustained may also be considered in the determination.

Personal care allowances may be adjusted up or down in the event that the circumstances following the original application substantially change.

## **#80.20 Amounts Payable at Each Level**

The amounts of personal care allowances are set out below.

	<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>	<b>Level 4</b>	<b>Level 5</b>
January 1, 1999–December 31, 1999					
Daily Amount	12.38	21.09	31.37	40.62	50.09
Monthly Amount	372.64	651.96	941.68	1,221.00	1,500.62
January 1, 2000–December 31, 2000					
Daily Amount	12.66	21.57	32.09	41.55	51.24
Monthly Amount	381.19	666.91	963.27	1,249.00	1,535.03
January 1, 2001–December 31, 2001					
Daily Amount	13.01	22.17	32.98	42.71	52.66
Monthly Amount	391.79	685.45	990.06	1,283.72	1,577.71
January 1, 2002–December 31, 2002					
Daily Amount	13.26	22.60	33.62	43.53	53.67
Monthly Amount	399.31	698.61	1,009.07	1,308.36	1,608.00

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

After January 1, 1993, the amounts of the personal care allowances will be adjusted on January 1 of each year. The Consumer Price Index ratio determined under Section 25 of the *Workers Compensation Act* for January 1 and the previous July 1 will be used (see #51.00).

### **#80.30 Payment Procedure**

Where the Board is paying the worker's actual expenses, it may pay directly the account of a company registered to provide the required assistance. The Board does not pay a personal care allowance directly to an individual attendant.

In a case where the worker is receiving a flat rate allowance or has hired an individual attendant, the amount is paid directly to the worker if he or she is capable of money management.

Once approved, personal care allowances are normally paid monthly. The worker, or the person providing the care, is required to complete and sign the prescribed form and return it to the Board each month, or at such other intervals as may be determined by the Board.

### **#80.40 Claimant Requires Institutional Care**

The payment of personal care expenses or allowances will be suspended if the claimant is institutionalized for more than fourteen calendar days, but may be reinstated upon returning home.

If a claimant is totally disabled and requires ongoing institutional care as a result, a flat rate personal care allowance will not be paid. The Board provides the cost of institutional care as part of the health care benefit program. If it appears that such a claimant can be provided the same kind of nursing or custodial care outside an institution, the Board may, as an alternative to paying personal care allowance, pay an amount calculated, at least in part, by reference to the cost of institutional care.

### **#81.00 INDEPENDENCE AND HOME MAINTENANCE ALLOWANCE**

Normally, most workers who are homeowners have the physical capacity to maintain their property in order to protect their investment in home and property. Such things as painting, repairing, landscaping, appliance repairs, renovations and the many other activities required to maintain the home are difficult or impossible for the disabled. The severely disabled claimant is usually required to hire tradespersons or others to carry out these activities, thereby incurring additional costs for maintaining home and property.

Similarly, the disabled claimant may not have the physical capacity to maintain and/or drive a car or to use public transportation, and is consequently required to hire taxis or other forms of transportation to enjoy a reasonable degree of independence.

In order to assist in these and similar kinds of expenses, the Board has established a category of assistance separate and distinct from personal care allowances, called the independence and home maintenance allowance. This allowance may be paid over and above any level of personal care allowance and is in addition to any wage-loss or pension benefits.

Effective September 1, 1992, the criteria for paying the independence and home maintenance allowance are as follows:

1. The worker must have sustained a permanent compensable disability which meets one of the following criteria:
  - (a) The disability measured using the physical-impairment method of assessment is equal to 75% of total or greater.
  - (b) The disability measured using the projected-loss-of-earnings method of assessment is equal to an equivalent of 75% of total or greater and it is concluded, after obtaining the advice of the Vocational Rehabilitation Consultant, that the disability will prevent the worker from carrying out the activities covered by the allowance.
  - (c) The compensable disability is superimposed on another permanently disabling medical condition, whether compensable or not, and the combined disability meets (a) above or the Board grants a projected-loss-of-earnings award which meets (b) above. Where the pre-existing disability is non-compensable, the compensable disability must be at least half the combined disability measured using the physical-impairment method of assessment and be a significant factor in the worker's inability to do the activities covered by the allowance.
2. The worker must maintain a home or live in rented accommodation. A worker who lives in a nursing hospital or extended care facility will not be eligible. Other accommodation may be approved if it can be concluded that the worker would have contributed to its maintenance had the disability not occurred.
3. If the worker is institutionalized in a hospital, nursing care facility or extended care facility, but the spouse and children continue to maintain the family home, the allowance may be paid to the spouse.
4. The allowance commences as of the date when the worker meets the criteria set out above and will be terminated upon the death of the worker or if the worker ceases to meet the above criteria. The allowance may be paid retroactively if time elapses between the date of the worker becoming eligible for the allowance and the date eligibility is determined. With regard to any period prior to September 1, 1992, no payment can be made unless the worker meets the criteria which existed prior to that date. (22)

The independence and home maintenance allowance is payable at the discretion of the Board. The circumstances surrounding each case will be reviewed by the Rehabilitation Consultant who will provide a report and recommendations.

Once the allowance is approved, the worker or spouse is required to complete and sign the appropriate form and submit it each month, or at such other intervals as may be determined by the Board.

The amount of the independence and home maintenance allowance is set out below.

<b>Date</b>	<b>Monthly Amount</b>
January 1, 1999 – December 31, 1999	\$196.99
January 1, 2000 – December 31, 2000	201.51
January 1, 2001 – December 31, 2001	207.12
January 1, 2002 – December 31, 2002	211.09

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

After January 1, 1993, the amount of the independence and home maintenance allowance will be adjusted on January 1 of each year. The Consumer Price Index ratio determined under Section 25 of the *Workers Compensation Act* for January 1 and the previous July 1 will be used (see #51.00).

The independence and home maintenance allowance is not retroactive to before June 13, 1980, but, subject to the claimant's qualifying as above described, the allowance is paid regardless of date of injury or permanent disability due to occupational disease.

## **#82.00 TRANSPORTATION ALLOWANCES**

Section 21(1) authorizes the Board to furnish or provide the injured worker with transportation it may deem reasonably necessary.

### **#82.10 Eligibility for Transportation**

Subject to the exceptions set out at the end of this item, return transportation expenses are normally reimbursed when:

1. A worker travels to a place of medical examination or treatment where the appointment has been previously approved by the Board or is subsequently paid for by the Board; or
2. A worker travels in connection with a vocational rehabilitation program where the travel is requested or approved as part of the program by the Vocational Rehabilitation Consultant; or

3. A worker is at the time of injury working at a place other than his or her place of residence and wishes to transfer to the place of residence and the disability from the injury prevents the worker from using the mode of transportation which he or she ordinarily would have used to do this; or
4. A worker meets the criteria set out in policy items #100.12 or #100.13 in connection with attendance at a claims or Review Division inquiry.

Transportation expenses are not normally paid in regard to:

1. Travel within the boundaries of a local bus service (including the area serviced by the Greater Vancouver Regional District transportation system) where the bus is a reasonable means of transportation for the worker.
2. The portion of any journey which takes place within a distance of 24 kilometres of the destination. This does not apply where the worker's condition is such as to require travel by:
  - (a) ambulance; or
  - (b) taxi, and the worker has received prior authorization for this from the Board.
3. The portion of any journey which takes place beyond the boundary of the province. This does not apply where the Board specifically requests the claimant to attend a medical examination, or in certain situations specified in policy item #100.15 in relation to claims or Review Division inquiries.

The Board may be ordered by the Workers' Compensation Appeal Tribunal to pay certain expenses. Section 7 of the *Workers Compensation Act Appeal Regulation* (B.C. Reg. 321/2002) provides that the Board may be ordered by the Workers' Compensation Appeal Tribunal to reimburse a party to an appeal under Part 4 of the *Act* for the following kinds of expenses:

- expenses associated with attending an oral hearing or otherwise participating in a proceeding, if the party is required by the Workers' Compensation Appeal Tribunal to travel to the hearing or other proceeding; and
- expenses associated with obtaining or producing evidence submitted to the Workers' Compensation Appeal Tribunal; and
- expenses associated with attending an examination required under section 249(8) of the *Act*.

However, the Workers' Compensation Appeal Tribunal may not order the Board to reimburse a party's expenses where those expenses arise from a person representing

the party or the attendance of a representative of the party at a hearing or other proceeding related to the appeal.

**EFFECTIVE DATE:** March 3, 2003 (as to references to the Review Division, the Workers' Compensation Appeal Tribunal and section 7 of the *Workers Compensation Act Appeal Regulation*)

**APPLICATION:** Not applicable.

### **#82.11**      *Worker Bypasses Nearby Medical Facilities*

Claimants may, of their own accord, bypass adequate local treatment facilities to attend a practitioner of their own choice elsewhere. The *Workers Compensation Act* allows freedom of choice of physician or qualified practitioner by the injured worker. Obviously, there must be some limitation of the costs of such freedom. For example, a worker in Prince George could not reasonably insist that since the physician or qualified practitioner of her or his choice worked in Vancouver, there should, therefore, be reimbursement for transportation to and from Vancouver to seek this medical care.

If, however, necessary medical care is only available in a given centre, or the Board, acting on the advice of the health professional, refers a worker to another centre for medical care, the costs of transportation will be chargeable to the Accident Fund.

If a worker, by choice, bypasses adequate local treatment facilities, transportation costs will not be paid. Adequate treatment facilities in this case are defined as physicians or hospitals in all cases. Since all other "qualified practitioners" are limited in the types and extent of care they can offer, it would not be reasonable to prohibit a worker from bypassing one of those practitioners to get to the nearest hospital or doctor. On the other hand, it would be unreasonable to allow a worker to bypass a hospital or a doctor to go to a "qualified practitioner". (23)

A worker may, following the injury, move his or her place of residence to another location and thereby incur increased transportation costs. This may or may not be because the worker was injured while working away from home. The Board will not normally pay the cost of the move from one place of residence to another. It will, however, pay normal transportation costs for travel from the place where the worker resides to a place of treatment or examination in the worker's area of residence even though the worker's choice of place of residence results in greater transportation costs. The Board will not pay for travel from the place of residence to a doctor in the worker's former residence unless the worker's condition requires treatment by that particular doctor.

### **#82.20**      **Amount of Reimbursement**

The principles set out below apply with regard to expenses incurred in connection with a claim or Review Division inquiry.

The Board will pay the cost of public transportation where this is available and is a reasonable and normal means of travel for the journey to be made by the worker. Where the Board consider it advisable, a worker will be encouraged to travel by air and the Board will assume the cost of the air fare, together with the cost of transportation to and from airports. In situations where air travel is acceptable and the worker elects to use some alternative means, such as the use of a private car, only the most reasonable and economical public transportation cost, which is usually the bus fare, will be reimbursed. Where air travel is not practical, and not approved, only the bus fare will normally be reimbursed irrespective of the method of travel utilized by the worker. The “bus fare” rate includes necessary meal costs and taxi costs to and from bus terminals.

Where public transportation is not reasonably available, the most economical method of transport that is reasonably available will be considered.

Taxi fares will be paid when medical reports indicate that the worker’s condition does not permit travel by public transportation. The worker must first obtain prior Board approval and will be required, if no voucher is provided, to obtain receipts from the taxi driver and submit the receipts for a refund.

Where there is no public transportation available, or it is deemed otherwise reasonable and acceptable for the worker to drive his or her own vehicle, an allowance of 28 cents per kilometre is paid, effective January 1, 1997, for journeys meeting the minimum kilometre limit set out in #82.10. Prior to January 1, 1997, the allowance was paid as follows:

<b>Date</b>	<b>Amount Per Kilometre</b>
January 1, 1999 - December 31, 1999	28¢
January 1, 2000 - December 31, 2000	29¢
January 1, 2001 - December 31, 2001	30¢
January 1, 2002 - December 31, 2002	30¢

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

It may, for example, be considered reasonable for a worker to drive his or her own vehicle where there is available public transport if the bus journey would involve multi bus transfers or coming by automobile would be acceptable where it permits the worker to put in half a day at work and still keep an appointment. Parking fees are payable if parking charges are levied by the hospital or medical building where the worker is attending for treatment, but are only paid where approval has been given to pay a kilometre allowance.

After January 1, 1993, the kilometre rate will be adjusted on January 1 of each year. The Consumer Price Index ratio determined under section 25 of the *Act* for January 1

and the previous July 1 will be used (see policy item #51.00). The result is rounded to the nearest cent.

Where a worker has voluntarily moved out of the province, eligible expenses are normally limited to what would be paid if the expenses were incurred in British Columbia. Where travel costs are being paid, the cost of travel back to British Columbia (usually the air fare) is prorated on a kilometre basis and the payment covers only the percentage of the travel occurring in British Columbia.

Parking fees may be payable where approval has been given to pay a kilometre/mileage allowance.

Where a worker has to buy meals while engaged in a journey for which the Board is paying expenses, the Board will pay the rates set out in policy item #83.20.

Flat rate travel allowances to cover the cost of different forms of transportation from different starting points to different destinations may be established. This includes situations where part of the journey takes place outside the province. These allowances should cover the normal cost of the journey in question including incidental costs such as parking, taxi, airporters, and meals which will usually be incurred in the journey. The amount of the allowance may be paid to the worker in place of actual expenses.

The worker in receipt of a flat rate payment may request reimbursement of actual expenses if, because of exceptional circumstances, expenses are incurred which are significantly higher than the amount of the flat rate. These expenses would have to meet the normal criteria for payment set out in this part of the manual.

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

### **#82.30 Manner of Payment**

Air travel is normally arranged through a travel agency used by the Board.

Travel arrangements may also be made by forwarding a cheque to the worker in advance of the scheduled trip. Normally, such advance payments will only be paid at the rate of the bus fare. In any exceptional situation where the cheque forwarded to the worker is to cover an air fare, but the worker elects to use other transportation that is less expensive, the Board will not ask for a refund of the difference in cost.

Where an advance payment has been made and the worker does not keep her or his appointment and another appointment cannot be arranged, the worker will be asked to return any transportation expenses that have been advanced. They will be treated as an overpayment. (24)

## **#82.40      Transportation Provided by the Employer**

Every employer shall, at its own expense, furnish to a worker injured in its employment, when necessary, immediate conveyance and transportation to a hospital, physician or qualified practitioner for initial treatment. (25) After such initial treatment, the Board provides any necessary transportation.

In the event a doctor is called to the scene of the accident, the employer shall be responsible for any charge made by the doctor with respect to mileage or travelling time. Where air transportation is utilized, stretchers suitable for use in planes shall be provided.

The transportation of an injured fisher to a hospital or physician or qualified practitioner is discussed in Fishing Industry Regulation 13 (found in Workers' Compensation Reporter Decision 223).

## **#82.50      Flight Changes**

Because of advance bookings, flight reservations made by the Board are normally at a preferred rate.

A worker may change a flight reservation or elect to fly after having previously advised that he or she will use some other means of transportation. This may result in increased flight cost. The Adjudicator will investigate the reasons for the change. If the investigation establishes that the change was necessitated for some emergency or other unavoidable reason, the Board will pay the costs incurred. If, however, it is shown that the change was due to a personal choice or preference on the part of the worker, the worker will either not be entitled to reimbursement of the additional costs incurred or may be required to reimburse that amount to the Board. The latter may be accomplished through a deduction from future wage-loss entitlements.

Claimants scheduled to travel by air are advised in advance of this policy.

## **#83.00      SUBSISTENCE ALLOWANCES**

The Board may make a daily allowance to an injured worker for subsistence when, under its direction, the worker is undergoing treatment at a place other than the place of residence. The power of the Board to make a daily allowance for subsistence extends to an injured worker who receives compensation, regardless of the date of first becoming entitled to compensation. (26)

### **#83.10 Eligibility for Subsistence**

Subsistence may be paid where a journey, for which the Board is paying transportation expenses (see #82.10), requires the worker to spend one or more nights away from home. It may continue to be paid for the duration of a treatment or vocational rehabilitation program which has been approved by the Board, and which requires the worker to spend a period of time away from home.

In determining whether a journey or program requires a worker to stay from home overnight, regard will be had to whether the worker can travel from home and return daily for a cost less than the amount that would be paid for subsistence.

Unless maintaining a connection to a place other than where the Board has directed the worker to be, no subsistence payments will be made. Maintaining a connection means paying a significant amount of rent, mortgage, or other fee or cost that guarantees a place for the worker to live upon return.

Where a worker is maintaining a residence close to work and also has a residence in another place, subsistence will not be paid while receiving treatment in either place. This is so even though the employer provides an allowance to cover the cost of the residence close to the work place and this ceases while the worker is disabled. However, the amount of the allowance is treated as part of the worker's earnings for the purpose of computing wage-loss benefits. (27)

No subsistence is payable where a worker receives accommodation at the Board's Rehabilitation Residence. This is so even though the worker elects to visit home or leave the Residence for some other purpose at a weekend. The Board will provide Residence accommodation to workers eligible for admission (28) who are not maintaining a connection to a place but who have been directed to travel to Richmond by the Board. In these cases, there will be no subsistence paid in lieu of Residence privileges.

Residence accommodation or subsistence is not available to workers who, at their own choice, simply choose to travel to Vancouver or any other centre for treatment or to await recovery.

### **#83.11 *Travelling Companions***

The following general rules will apply with regard to subsistence payments and Residence accommodation for travelling companions, attendants or visitors for injured workers. Reimbursement of costs for persons other than the worker does not include any wage or income loss incurred.

1. Where it is medically necessary, the Claims Adjudicator will authorize subsistence payments or Rehabilitation Residence accommodation for one night for a travelling companion to take a patient to a treatment centre, medical examination or meeting in any city where it is not reasonable to expect the travelling companion to return home that day. Another night may be allowed to accompany the patient home if he or she is required to stay more than one day at that centre and a travelling companion is medically necessary in the opinion of the Adjudicator. (In case of emergency, other designated Board officers may authorize travel and subsistence.) Where it is not necessary for the travelling companion to stay overnight, travel costs and appropriate meal allowances will be paid.
2. Where an injured worker is in critical condition in a hospital, a spouse, relative or other person from the worker's residence with a close attachment to the injured worker may receive transportation costs, subsistence payments or Residence accommodation as long as the worker remains in critical condition.
3. Where an injured worker has sustained a major amputation and the presence of a spouse or parent is deemed advisable, the spouse or parent may receive transportation costs, subsistence payments or residence accommodation to visit with the injured worker, during the early stages of treatment and the fitting of a prosthesis in the Rehabilitation Centre.

Approval for these visits is recorded on the claim and requires approval from the Amputee Group Physician and the Manager of the Rehabilitation Centre<sup>1</sup> or their delegates.

4. Where under Board sponsorship or direction a worker is undergoing a period of treatment or retraining which requires the worker to live elsewhere than her or his normal residence for a period of six weeks or more, the Adjudicator will, on not more than one occasion every three weeks pay for a visit home by the worker or, in lieu of this, authorize subsistence payments or Residence accommodation for up to two nights plus transportation costs for a spouse, relative or other person from the worker's residence with a close personal attachment to the worker visiting the worker. Where the trip involves travel outside of British Columbia, the Board will prorate the airfare on a mileage basis and only pay the portion from the British Columbia border. This proration may, at the discretion of a Director in the Compensation Services Division, be waived in the case of a spouse, relative or other person from the worker's residence with a close attachment to the injured worker who is visiting a worker in critical condition in a hospital.

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<sup>1</sup> The "Claims Department" no longer exists.

The payment of transportation costs includes the costs of meals where necessary. Any visit home not meeting the above criteria must be at the worker's own expense. No subsistence allowances will be paid if a worker elects not to return home but lives elsewhere than the Residence over a weekend.

5. Where the Adjudicator feels that there are other circumstances where subsistence or Residence accommodation for a person with a close attachment to the injured worker is appropriate, one night may be allowed and the reason for so doing noted on the claim with a copy sent to a Director in the Compensation Services Division. Where a longer stay is felt to be appropriate, the Adjudicator may request subsistence or Residence privileges from a Director in the Compensation Services Division. In these cases, the reasons and the claim should be forwarded for decision but this requirement may be dispensed with at the discretion of a Director in the Compensation Services Division.
6. Where a spouse attends a chronic pain clinic at which the claimant is being treated, travelling expenses and subsistence allowances are payable.

The Claims Adjudicator will normally accept the judgment of the attending physician as to whether a travelling companion should accompany the claimant or whether the worker's condition is considered critical.

### *#83.12 Visits Home by Worker*

Where under Board sponsorship, a worker is undergoing a program of retraining away from her or his residence and the course of retraining is one of six weeks or more duration, the same provisions as listed in #83.11, item 4 apply.

### *#83.13 Income Loss*

In situations where a worker who is not deemed disabled from working loses time from work to attend treatment or examination by a physician or qualified practitioner or for other authorized treatment, a payment through health care benefit funds can be made. These situations will either involve a worker who has never been declared disabled as the result of the injury or occupational disease, or has returned to work following a period of disability, but is still undergoing treatment. The payment is normally equal to 75% of the worker's actual current loss. However, it is subject to the same rules as to the maximum and minimum as are applicable to temporary total disability benefits. (See #34.20 and #69.00.)

Such payments are made where it is deemed unreasonable for the worker to attend for the examination(s) or treatment(s) outside of working hours. Generally, there will be no reimbursement if the loss incurred is under two hours, however, multiple losses, which in the aggregate accumulate to a significant loss,

may qualify for payment. While these payments are not wage-loss compensation, the provisions of Section 5(2) of the *Workers Compensation Act* will be followed. As such, no income-loss subsistence will be paid for losses incurred on the day of the injury.

If a loss is due either to the worker's personal selection of a physician or qualified practitioner which involves bypassing closer treatment facilities, this will be taken into account when evaluating an entitlement to income-loss subsistence.

In situations where the worker is maintained on full salary by the employer and an entitlement to income-loss subsistence has accrued, the payment will be made to the employer under the terms of Section 34 of the *Workers Compensation Act*.

### **#83.20 Rates of Subsistence**

"Subsistence" means the costs of accommodation and meals.

The Board will normally reimburse actual accommodation costs. (In the case of visits to Richmond, workers will be accommodated in the Richmond Residence.) When contacting the worker prior to departing from home, the Board officer will reach an agreement with the worker regarding the accommodation to be selected and the amount the Board is prepared to approve as a reimbursement.

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

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

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

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

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

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

<b>Date</b>	<b>Amount Per Day</b>
January 1, 1999 - December 31, 1999	\$16.31
January 1, 2000 - December 31, 2000	16.68
January 1, 2001 - December 31, 2001	17.14
January 1, 2002 - December 31, 2002	17.47

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

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

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

## **#84.00 REHABILITATION RESIDENCE**

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

### **#84.10 Eligibility For Admittance**

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

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

The following categories for Residence admission eligibility have been established.

#### *#84.11 Rehabilitation Centre Treatment*

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

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

1. the costs of travel are high;
2. the consequences of missing an important appointment are too great; or
3. travel arrangements are difficult.

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

#### *#84.12 Medical Consultation or Disability Evaluation*

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

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

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

### **#84.13      *Rehabilitation Programs***

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

#### **A.    Rehabilitation Centre Vocational Assessment Programs**

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

#### **B.    Training and Education Programs**

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

### **#84.14      *Rehabilitation Residence Filled***

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

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

### **#84.20      *Right of Eligible Workers to Choose Own Accommodation***

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

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

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

but chooses not to do so. The use of automobiles will be permitted where it is unreasonable to expect the patient to use public transport.

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

### **#84.30 Visits to and from Home**

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

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

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

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

### **#84.40 Conduct of Worker at the Rehabilitation Residence**

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

### **#84A.00 HOMEMAKERS SERVICES**

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

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

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

The Board does, however, recognize cases in which the provision of homemakers' services on a temporary basis should be considered, particularly in instances where a worker is away overnight. The Board will pay for such services under appropriate circumstances.

The criteria for the payment of a homemakers' service will be:

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

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

The allowance will normally be paid to the claimant.

## NOTES

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

