

## CHAPTER 12

### CLAIMS PROCEDURES

#### #92.00 INTRODUCTION

This chapter relates to the roles and responsibilities of workers, employers, physicians, and the Board in the making and adjudicating of compensation claims.

#### #93.00 RESPONSIBILITIES OF CLAIMANTS

##### #93.10 Report to Employer

Section 53(1) provides that "In every case of an injury or disabling occupational disease to a worker in an industry within the scope of this Part, the worker, or in case of death the dependant, must as soon as practicable after the occurrence inform the employer by giving information of the disease or injury to the superintendent, first aid attendant, supervisor, agent in charge of the work where the injury occurred or other appropriate representative of the employer, and the information must include the name of the worker, the time and place of the occurrence, and, in ordinary language, the nature and cause of the disease or injury."

Where the worker's condition results from a series of injuries rather than just one injury, section 53(1) is complied with if the report to the employer is made as soon as practicable after the last injury in the series.

In the case of an occupational disease, the employer to be informed of the death or disablement is the employer who last employed the worker in the employment to the nature of which the disease was due. (1)

Where the injury or disease is suffered by a commercial fisher, the "employer" to whom the fisher must report is set out in section 10 of the *Fishing Industry Regulations*.

**EFFECTIVE DATE:** March 18, 2003 (as to the deletion of reference to the *Workers' Compensation Reporter* Decision No. 223)

**APPLICATION:** Not applicable.

### *#93.11 Procedure for Reporting*

There is no requirement as to the form of the notice. It may be written or oral. However, the worker shall, if fit to do so and on request of the employer, provide to the employer particulars of the injury or occupational disease on a form prescribed by the Board and supplied by the employer. (2)

For the convenience of employers, the Board has prepared a form for the worker's report. This form, "Worker's Report of Injury or Occupational Disease to Employer", is called Form 6A. As long as the employer uses exactly this form prescribed by the Board, the worker is required by law to complete the form as long as fit to do so, and requested to do so by the employer.

There is no law which prevents an employer from using another form for the purpose of a worker's report, and including such questions as the employer may wish. But if another form is used, it must not be described as a form supplied or prescribed by the Board, and the worker is not required by law to complete it.

If the employer does not have all of the information requested on the Form 7, (3) the employer is not required to obtain it from the worker. The obligation of an employer, when completing a Form 7, is to investigate the reported injury or occupational disease and to provide the Board with the information obtained. (4)

Many employers set up their own system of reporting to assist them in carrying out their obligations. If the worker, however, reports to some other company official who was not designated by the employer, this does not mean there is no compliance with his or her responsibilities under the *Act*.

### *#93.12 Failure to Report*

Section 53(4) provides that a "Failure to provide the information required by this section is a bar to a claim for compensation . . . , unless the board is satisfied that

- (a) the information, although imperfect in some respects, is sufficient to describe the disease or injury suffered, and the occasion of it;
- (b) the employer or the employer's representative had knowledge of it; or
- (c) the employer has not been prejudiced, and the board considers that the interests of justice require that the claim be allowed."

The evidence may show that it was practicable for a worker to report the injury or disease to the employer long before such a report was actually made. In such a case, there will be "Failure to provide the information required by this section " within the meaning of section 53(1).

## **#93.20      Application for Compensation**

Section 55(1) provides in part that "An application for compensation must be made on the form prescribed by the board or the regulations and must be signed by the worker or dependant . . ."

Where the Board receives a report that a worker has suffered an injury or disease which will likely cause a loss of wages, it will automatically forward a Form 6, Application for Compensation and Report of Injury or Occupational Disease. The worker should complete this form and return it to the Board. In the case of someone covered by personal optional protection, the application is made on a Form 6/7, Independent Operator's Application for Compensation and Report of Injury, but a Form 6 may also be used.

For applications for compensation in respect of hearing loss, reference should also be made to policy item #31.30. In the case of occupational diseases, reference should be made to policy items #32.50 - #32.58.

## **#93.21      *Time Allowed for Submission of Application***

Section 55(2) provides that "Unless an application is filed, or an adjudication made, within one year after the date of injury, death or disablement from occupational disease, no compensation is payable, except as provided in subsections (3), (3.1), (3.2) and (3.3)." (Subsections (3) and (3.1) are discussed in policy item #93.22.)

Where the worker's condition results from a series of injuries rather than just one injury, section 55(2) is complied with if the application is filed within one year of the last injury in the series.

The section is not complied with simply by reporting the injury to the first aid attendant or having it confirmed by witnesses. The one-year period commences at the date of injury or death, and except in the case of occupational diseases, not at the date of subsequent disablement. In the case of occupational diseases, reference should be made to policy item #32.50.

## *#93.22 Application Made Out of Time*

Before an application for compensation can be considered on its merits, it must satisfy the requirements of section 55. It is important to distinguish between the decision on the merits of the claim and the decision made under section 55, since the distinction may affect the rights of appeal which a person has to challenge the decision. A separate decision on the effect of Section 55 must always be reached on a claim.

Sections 55(3), (3.1), (3.2), and (3.3) provide as follows:

- "(3) If the Board is satisfied that there existed special circumstances which precluded the filing of an application within one year after the date referred to in subsection (2), the Board may pay the compensation provided by this Part if the application is filed within 3 years after that date.
- (3.1) The Board may pay the compensation provided by this Part for the period commencing on the date the Board received the application for compensation if
  - (a) the Board is satisfied that special circumstances existed which precluded the filing of an application within one year after the date referred to in subsection (2), and
  - (b) the application is filed more than 3 years after the date referred to in subsection (2).
- (3.2) The Board may pay the compensation provided by this Part if
  - (a) the application arises from death or disablement due to an occupational disease,
  - (b) sufficient medical or scientific evidence was not available on the date referred to in subsection (2) for the Board to recognize the disease as an occupational disease and this evidence became available on a later date, and
  - (c) the application is filed within 3 years after the date sufficient medical or scientific evidence as determined by the Board became available to the Board.
- (3.3) Despite section 96(1), if, since July 1, 1974, the Board considered an application under the equivalent of this section in respect of death or disablement from occupational disease, the Board may reconsider that application, but the Board must apply subsection (3.2) of this section in that reconsideration.

The general effect of these provisions is that two requirements must be met before an application received outside the one year period can be considered on its merits. These are:

1. There must have existed special circumstances which precluded the application from being filed within that period, and
2. The Board must exercise its discretion to pay compensation.

The application cannot be considered on its merits if no such special circumstances existed or the Board declines to exercise its discretion in favour of the worker. Each of these two requirements of section 55(3) must be considered separately.

1. Special Circumstances

It is not possible to define in advance all the possible situations that might be recognized as special circumstances which precluded the filing of an application. The particular circumstances of each case must be considered and a *judgment made*. However, it should be made clear that in determining whether special circumstances existed, the concern is solely with the worker's reasons for not submitting an application within the one-year period. No consideration is given to whether or not the claim is otherwise a valid one. If the worker's reason for not submitting an application in time are not sufficient to amount to special circumstances, the application is barred from consideration on the merits, notwithstanding that the evidence clearly indicates that the worker did suffer a genuine work injury.

The following facts illustrate a situation where special circumstances were found to exist. The worker suffered a minor right wrist injury on October 20, 1976, which at the time caused him no disablement from work and did not require him to seek medical attention. There was, therefore, no reason why he should claim compensation from the Board, nor any reason why his doctor or employer should submit reports to the Board. It was not until 1978 when the worker began to experience problems with his right wrist that he submitted a claim to the Board. It was only then that he was incurring monetary losses for which compensation might be appropriate.

2. Discretion of the Board

Assuming the Board accepts that there were special circumstances that precluded the worker from submitting an application within the one-year period, the second requirement of section 55(3) must then

be dealt with. The question arises as to whether or not the Board should exercise its discretion to pay compensation.

Once special circumstances within the meaning of section 55(3) have been shown to exist, the Board should in general exercise its discretion under that section in favour of allowing workers' applications to be considered on their merits. However, the Board cannot automatically exercise its discretion in every case in this way without having regard to the particular facts of each claim.

The exercise of the Board's discretion depends on the extent to which the lapse of time since the injury has prejudiced the Board's ability to carry out the necessary investigations into the validity of the claim. The length of time elapsed will be a significant factor here, together with the nature of the injury. Also significant will be whether there are witnesses or other persons to whom the worker reported the injury and from whom he sought treatment for it who are still able to provide accurate statements to the Board. The Board will not exercise its discretion under section 55(3) in favour of allowing an application to be considered where, because of the time elapsed, sufficient evidence to determine the occurrence of the injury and its relationship to the worker's complaints cannot now be obtained.

The facts of the case discussed above illustrate a situation where, even though there were special circumstances precluding the worker from submitting his application within the one-year period, the Board decided to exercise its discretion against allowing the worker's application to be considered on its merits. The fact that the initial injury was a minor one which caused no immediate problems and required no medical treatment meant that it was impossible to obtain detailed evidence as to the real nature of the original injury. Furthermore, this was a case where detailed medical evidence of this nature would be particularly necessary since, on the face of it, it would be hard to relate the worker's complaints to such a minor injury two years before.

The exercise of the Board's discretion under section 55(3) may, in some cases, appear in substance to be closely related to the question that would arise on the merits of the claim as to whether the injury in question occurred and whether it caused the worker's subsequent complaints. If there is now an inability to obtain evidence regarding the original injury, that would normally mean that the claim would be disallowed on the merits for lack of evidence to support it. On the other hand, there will be cases where, notwithstanding the Board's exercising its discretion in favour of allowing an application to be considered the claim will

nevertheless be disallowed on the merits. For the reason connected with the appeals system outlined at the beginning of policy item #93.22 it is always necessary, in any event, to separate the decision on the merits and the exercise of discretion under section 55(3).

Where an application for compensation received outside the one-year period is considered on its merits by virtue of section 55(3), the date of receipt of the application will be the effective date for the purpose of calculating any entitlement to interest under policy item #50.00.

**EFFECTIVE DATE:** June 1, 2009 – Delete reference to Board officer.  
**HISTORY:** March 3, 2003 – Insert new wording of section 55(3.3)  
**APPLICATION:** Applies on or after June 1, 2009

### *#93.23 Adjudication without an Application*

Where the Board is satisfied that compensation is payable, it may be paid without an application. (5)

In accordance with this provision, the Board may pay all the compensation due on a claim without first receiving an application from the worker. However, the Board will not normally do this in certain types of cases, notably the following:

1. The employer is objecting to the claim.
2. The claim is doubtful.
3. A disability award may result.
4. In personal optional protection cases before wage loss is payable.
5. Where a preliminary determination under policy item #96.21 is carried out.
6. In third-party and out-of-province cases.
7. Silicosis claims.
8. On fatal claims before a pension can be paid. A decision on the acceptability of the claim and the payment of funeral and lump-sum benefits can be made without an application.

Claims are generally not paid without a worker's application form unless there is a report from the employer or other equivalent documentation and a medical report on file. The Board can however exercise discretion where the circumstances warrant a deviation from this requirement.

The Board will not accept a claim and pay compensation where the worker indicates that she or he does not wish to claim.

**EFFECTIVE DATE:** June 1, 2009 – Delete references to Board officer.  
**HISTORY:** March 3, 2003 – Amended to reference preliminary determinations under policy item #96.21.  
**APPLICATION:** Applies on or after June 1, 2009

### **#93.25**      *Signature on an Application for Compensation*

The application for compensation must be signed by the worker. (6) Printed signatures are not acceptable, except in the case of claimants whose education has been in a different script, for example, claimants of East Indian or Chinese origin. A carbon copy of a signature is not acceptable.

An “X” in lieu of signature is acceptable if the worker is unable to sign because of the injury or he or she is illiterate. Such a signature must be countersigned by a responsible adult. It is preferable but not mandatory that the signature should read “witnessed by” followed by the countersignor’s signature and address.

If the worker is unconscious, has a severe head injury, is of unsound mind, or has some other condition which prevents the signing of an application, the Board may accept an application signed by someone on the worker’s behalf. This might be a spouse, mother, father, relative, etc. If the worker is married, the person who signs should normally be the spouse. If the worker is single, it should normally be the mother or father.

Unless otherwise disabled, a worker under the age of 19 years can and should sign the application form. (7)

### **#93.26**      *Obligation to Provide Information*

Section 57.1 of the *Act* provides as follows:

- (1) A worker who applies for or is receiving compensation must provide the Board with the information that the Board considers necessary to administer the worker’s claim.
- (2) If a worker fails to comply with subsection (1) the Board may reduce or suspend payments to the worker until the worker complies.

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

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

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

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

Notification to the worker must specify:

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

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

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

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

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

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

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

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

**EFFECTIVE DATE:** June 1, 2009 – Update reference to Human Resources and Skills Development Canada and Canada Revenue Agency.

**APPLICATION:** Applies on or after June 1, 2009

### **#93.30 Medical Treatment and Examination**

The obligations of an injured worker to undertake medical treatment and examination are discussed in policy item #78.00.

### **#93.40 Working While Receiving Wage-Loss Benefits**

A worker is obliged to report to the Board any earnings which are received while being paid wage-loss benefits. Such earnings will be taken into account in computing wage-loss benefits under the rules discussed in policy item #35.00

## **#94.00 RESPONSIBILITIES OF EMPLOYERS**

### **#94.10 Report to the Board**

Subject to policy items #94.12 and #94.13, an employer shall report to the Board within three days of its occurrence every injury to a worker that is or is claimed to be one arising out of and in the course of employment.

Subject to policy items #94.12 and #94.13, an employer shall report to the Board within three days of receiving information under section 53, (8) every disabling occupational disease, or claim for or allegation of an occupational disease.

An employer shall report immediately to the Board and to its local representative the death of a worker where the death is or is claimed to be one arising out of and in the course of employment. (9)

The application of the above provisions to claims by commercial fishers is discussed in sections 4 and 10 of the *Fishing Industry Regulations*.

**EFFECTIVE DATE:** March 18, 2003 (as to the deletion of references to the *Workers' Compensation Reporter* Decision Nos. 223 and 224)

**APPLICATION:** Not applicable.

### **#94.11**      *Form of Report*

The report shall be on the form prescribed by the Board and shall state:

1. the name and address of the worker;
2. the time and place of the disease, injury, or death;
3. the nature of the injury or alleged injury;
4. the name and address of any physician or qualified practitioner who attended the worker; and
5. any other particulars required by the Board or by the regulations, and may be made by mailing copies of the form addressed to the Board at the address the Board prescribes.

The Board has prescribed forms for employers to report injuries, deaths, or occupational diseases. These are as follows:

- |        |   |
|--------|---|
| Form 7 | Employer's Report of Injury or Occupational disease   |
| Form 9 | Employer's Subsequent Statement (Completed at the employer's option or at the Board's request, as soon as the injured worker has returned, or is able to work.) |

The report must be approved by an authorized official of the employer other than the worker.

### **#94.12**      *What Injuries Must Be Reported*

A reportable injury is an injury arising out of and in the course of employment, or which is claimed by the worker concerned to have arisen out of and in the course of such employment, and in respect of which any one of the following conditions is present or subsequently occurs.

1. The worker loses consciousness following the injury, or
2. The worker is transported, or directed by a first aid attendant or other representative of the employer to a hospital or other place of medical treatment, or is recommended by such person to go to such place, or
3. The injury is one that obviously requires medical treatment, or
4. The worker states an intention to seek medical treatment, or
5. The worker has received medical treatment for the injury, or
6. The worker is unable or claims to be unable by reason of the injury to return to his or her usual job function on any working day subsequent to the day of injury, or
7. The injury or accident resulted or is claimed to have resulted in the breakage of an artificial member, eyeglasses, dentures, or a hearing aid, or
8. The worker or the Board has requested that an employer's report be sent to the Board.

Section 54(6) provides that “. . . the board may by regulation

- (a) define and prescribe a category of minor injuries not required to be reported under this section; . . .”

Where none of the conditions listed 1 to 8 above are present, an injury is a minor injury and not required to be reported to the Board unless one of those conditions subsequently occurs.

### **#94.13      *Commencement of the Obligation to Report***

The obligation of the employer to report the injury to the Board commences when a supervisor, first aid attendant, or other representative of the employer first becomes aware of any one of the conditions listed in policy item #94.12, or when notification of any such condition is received by mail or telephone at the local or head office of the employer. (10)

An employer who protests a claim should take care not to delay the submission of the Form 7 employer's report to the Board. If the employer wishes to investigate further, the employer should submit the Form 7 stating that an investigation report will follow, and give reasons for the delay.



At the end of each six-month period, a review is undertaken of employers who have been late in filing their reports of injury to the Board. As a result of this review, a first letter may be sent out to defaulting employers informing them of their records over the past six months and warning them of the effect of the section. At the end of the following six-month period, any employers who received the initial letter and who continue to default will receive a second letter. This will warn them that, on any future claims where an interim adjudication is made under section 54(7) accepting the claim, they will be charged with the full amount of costs incurred up to the elapse of three days from the receipt of their employer's report.

Prior to charging the cost of any particular claim to an employer under section 54(8), the Board will first send a letter asking if there is any reason why the employer should be excused from the penalty. Following the employer's reply or if there is no reply, the Board will then make a decision and notify the employer.

Set out below are some reasons why employers may be excused for late reporting. These are guidelines only, as each case must be considered individually.

1. The worker lays off some time after the day of the injury and when the days are counted from the date of lay-off to the date of the Form 7's arrival, they number fewer than ten.
2. A report is requested by the Board to start a new claim after investigation of a reopening indicates a new incident. However, the Form 7 must be received within three days from the date the firm is notified of the new claim.
3. The worker does not report the incident to the employer until some time after the lay-off.
4. There is no wage loss involved and the employer was not aware the worker sought medical attention.
5. The decision to accept the claim is made on the 11th day after the injury, and the Form 7 arrived at the Board, but not on file, before the 10th day.

The costs charged to the employer will consist of all health care benefits, rehabilitation, and wage-loss payments relating to the period in question, even though they are not actually paid until some time afterwards.

The employer will continue to be charged with the costs incurred on claims on which the employer is late in reporting until the overall reporting record is shown to have improved sufficiently at a subsequent six-month review.

The term “interim adjudication” used in this context should not be confused with the term “preliminary determination” when it applies to the processing of payments on an apparently acceptable claim in the absence of some information which is likely to be delayed. The latter procedure is set out in policy item #96.21. The requirements of the preliminary determination procedure do not have to be met for an interim adjudication under section 54(7). It is sufficient if the claim does appear to be an acceptable one and is only being held up by the technicality of the employer’s failure to submit a report.

When the Form 7 employer’s report does arrive, it can be considered as evidence in making the final adjudication of the claim. The rules set out in policy item #96.21 regarding the non-recovery of payments made under a preliminary determination also apply here. If the employer’s report protests the acceptance of the claim, but the final adjudication is that it remains allowed, the employer will receive the usual notification of the relevant rights of review and/or appeal.

The above procedure applies to pay employer claims (12) and to employers with deposit accounts, but not to personal optional protection or Federal Government claims.

Unless the Board receives the Form 7 employer’s report, the interim adjudication becomes the final decision on the acceptability of the claim and is subject to the provisions of section 96(5) of the *Act*.

If the Board receives the Form 7 employer’s report, the final adjudication becomes the final decision on the acceptability of the claim and is subject to the provisions of section 96(5) of the *Act*.

The final adjudication does not constitute a reconsideration of the interim adjudication for purposes of sections 96(4) and (5). Section 54(7) contemplates that a final adjudication will be made, whenever the Form 7 employer’s report is received.

**EFFECTIVE DATE:** June 1, 2009 – Delete references to Board officer.  
**HISTORY:** March 3, 2003 – Insert references to preliminary determination and the status of final adjudication for the purposes of sections 96(4) and (5).  
**APPLICATION:** Applies on or after June 1, 2009

## **#94.20 Employer or Supervisor Must Not Attempt to Prevent Reporting**

Section 177 of the *Act* provides as follows:

An employer or supervisor must not, by agreement, threat, promise, inducement, persuasion or any other means, seek to discourage, impede

or dissuade a worker of the employer, or a dependant of the worker, from reporting to the board

- (a) an injury or allegation of injury, whether or not the injury occurred or is compensable under Part 1,
- (b) an illness, whether or not the illness exists or is an occupational disease compensable under Part 1,
- (c) a death, whether or not the death is compensable under Part 1, or
- (d) a hazardous condition or allegation of hazardous condition in any work to which this Part applies.

The Board may impose an administrative penalty if it is determined that an employer has violated section 177. The general criteria for calculating administrative penalties are provided in the *Prevention Manual* at item D12-196-6. The “basic amount” of the administrative penalty will normally be determined in accordance with the amounts established for a “Category B Penalty”. Where the non-compliance was willful or with reckless disregard, the penalty may be determined in accordance with the amounts established for a “Category A Penalty”.

Policy item D12-196-6 also provides for the recovery of costs saved through non-compliance. The amount of any costs saved or profit made by the employer through committing the violation shall, as far as known, be added to the penalty amount.

As an alternative to imposing an administrative penalty, the Board may refer the case to Crown Counsel for consideration of prosecution.

## **#95.00 RESPONSIBILITIES OF PHYSICIANS/QUALIFIED PRACTITIONERS**

It is the duty of every physician or qualified practitioner (13) attending or consulted on a case of injury to a worker, or alleged case of injury to a worker, in any industry within the scope of Part 1 of the *Act* to furnish reports in respect of the injury in the form required by the regulations or by the Board.

The first report containing all information requested in it shall be furnished to the Board within three days after the date of the physician’s or qualified practitioner’s first attendance upon the worker.

If treatment continues, progress reports must be provided.

The physician or qualified practitioner must furnish a report within three days after the worker is, in the opinion of the physician or qualified practitioner, able to resume work and, if treatment is being continued after resumption of work, furnish further adequate reports. (14)

The duties described in this policy item apply to a physician or psychologist who diagnoses a worker with a mental stress condition under section 5.1(1)(b) of the *Act*.

**EFFECTIVE DATE:** December 31, 2003.

**APPLICATION:** On December 31, 2003, this policy was amended to reflect the amendment of section 5.1(1) of the *Act* and the introduction of sections 5.1(2) to (4) of the *Act*. The amended policy applies to injuries on or after December 31, 2003.

## **#95.10 Form of Reports**

The Board has prescribed forms for each type of report, the most common of which are as follows:

- Form 8 Physician's First Report
- Form 11 Physician's Progress Report
- Form 11A Physician's Report and Account

Similar forms are provided for qualified practitioners and other persons authorized to treat workers under the *Act*.

All medical reports must be signed by the person making the report with reference to the professional designation of a partnership or clinic. The original report, not the carbon copy, should be provided to the Board. Any change in status of a partnership or clinic, or change in its address, should be reported to the Board without delay to assure proper direction of payment.

## **#95.20 Reports by Specialist**

If the physician is a specialist whose opinion is requested by the attending physician, the worker, or the Board, or if he or she continues to treat the worker after being consulted as a specialist, a first report must be furnished to the Board within three days after completion of the consultation; but if the specialist is regularly treating the worker, the specialist shall submit reports as required in policy item #95.00. (15)

Section 1 defines a “specialist” as “. . . a physician residing and practising in the Province and listed by the Royal College of Physicians and Surgeons of Canada as having specialist qualifications.”

### **#95.30 Failure to Report**

Physicians, qualified practitioners, or other persons who fail to submit prompt, adequate and accurate reports and accounts as required by the *Act* or the Board commit an offence, and their right to be selected by a worker to render health care may be cancelled by the Board, or they may be suspended for a period to be determined by the Board. When the right of a person to render health care is so cancelled or suspended, the Board shall notify the person of the cancellation or suspension, and shall likewise inform the governing body named in the *Act* under which the person is authorized to treat human ailments, and the person whose right to render health care is cancelled or suspended shall also notify any injured workers who seek treatment from him or her of the cancellation or suspension. (16)

The maximum fine for the offence committed under the *Act* is set out in Appendix 6.

The Board may refuse to pay accounts where reports are inadequate.

### **#95.31 *Payment of Wage-Loss without Medical Reports***

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

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

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

evidence of that disability is almost always medical evidence, but on some occasions, evidence from the worker or from other sources may be sufficient to establish the existence and continuation of the disability.

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

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

## **#95.40      Obligation to Advise and Assist Worker**

The physician or qualified practitioner must give all reasonable and necessary information, advice, and assistance to the injured worker and the worker's dependants in making application for compensation, and in furnishing in connection with it the required certificates and proofs, without charge to the worker. (17) This duty applies to a physician or psychologist who diagnoses a worker with a mental stress condition under section 5.1(1)(b) of the *Act*.

**EFFECTIVE DATE:**            December 31, 2003.

**APPLICATION:**            On December 31, 2003, this policy was amended to reflect the amendment of section 5.1(1) of the *Act* and the introduction of sections 5.1(2) to (4) of the *Act*. The amended policy applies to injuries on or after December 31, 2003.

## **#96.00      THE ADJUDICATION OF COMPENSATION CLAIMS**

Section 96(1) of the *Act* provides that "Subject to sections 239 and 240, the Board has exclusive jurisdiction to inquire into, hear and determine all matters and questions of fact and law arising under this Part, and the action or decision of the Board on them is final and conclusive and is not open to question or review in any court, and proceedings by or before the Board must not be restrained by injunction, prohibition or other process or proceeding in any court or be removable by certiorari or otherwise into any court, and an action may not be maintained or brought against the Board or a director, an officer, or an employee of the Board in respect of any act, omission or decision that was within the jurisdiction of the Board or that the Board, director, officer or employee believed was within the jurisdiction of the Board, and, without restricting the generality of the foregoing, the Board has exclusive jurisdiction to inquire into, hear and determine

- (a) the question whether an injury has arisen out of or in the course of an employment within the scope of this Part;

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

**EFFECTIVE DATE:** March 3, 2003 (as to new wording of section 96(1))  
**APPLICATION:** Not applicable.

## **#96.10 Policy of the Board of Directors**

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

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

- (a) The statements contained under the heading “Policy” in the *Assessment Manual*;
- (b) The *Occupational Safety and Health Division Policy and Procedure Manual*;
- (c) The statements contained under the heading “Policy” in the *Prevention Manual*;

- (d) The *Rehabilitation Services & Claims Manual* Volume I and Volume II, except statements under the headings “Background” and “Practice” and explanatory material at the end of each Item appearing in the new manual format;
- (e) The *Classification and Rate List*, as approved annually by the Board of Directors;
- (f) *Workers’ Compensation Reporter* Decisions No. 1 – 423 not retired prior to February 11, 2003; and
- (g) Policy decisions of the former Governors and the former Panel of Administrators still in effect immediately before February 11, 2003.

After February 11, 2003, the policies of the Board of Directors consist of the documents listed above except for the Occupational Safety and Health Division *Policy and Procedure Manual* (which was retired effective December 31, 2003) and any *Workers’ Compensation Reporter* Decisions No. 1 – 423 which have been retired since February 11, 2003. Policies of the Board of Directors also include amendments to policy in the policy manuals, any new or replacement manuals issued by the Board of Directors, any documents published by the Board that are adopted by the Board of Directors as policies of the Board of Directors, and all decisions of the Board of Directors declared to be policy decisions.

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

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

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

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

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

WCAT decisions do not become policy of the Board of Directors by virtue of having been published in the *Workers’ Compensation Reporter*. WCAT

decisions are published in the *Reporter* to provide guidance on the interpretation of the *Act*, the Regulations and Board policies, practices and procedures.

**EFFECTIVE DATE:** March 3, 2003 (as to deletion of references to how policy is to be applied)

**APPLICATION:** Not applicable.

### *#96.21 Preliminary Determinations*

A preliminary determination on a claim will be made, to provide temporary financial relief to the worker until the Board receives the information necessary to make a decision on the validity of the claim, when the following conditions are present:

1. The worker appears to be currently disabled from work.
2. On the available evidence, it appears probable that the worker is suffering from a compensable injury or occupational disease, or at least it appears that the evidence is evenly weighted.
3. There is some significant delay in obtaining evidence necessary to arrive at a conclusion on the validity of the claim, and the Board is unable to avoid that delay.
4. The worker is not causing the delay.
5. The delay appears to be causing an interruption of income for the worker. For example, the case is not one in which the worker is still being paid by the employer or another source.
6. The claim is not a third party one. (19)
7. An application for compensation has been received.

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

When a preliminary determination is made, the following rules will apply:

1. Wage-loss benefits will be commenced, with an explanation to the worker, employer and attending physician.
2. Payments of wage-loss benefits under the preliminary determination will commence as of the date when the Board makes the determination. Arrears of wage-loss benefits for any time period prior to that date will not be paid until a decision on the validity of the claim is made, except that the Board may pay such

arrears on a preliminary determination to the extent that this may be necessary to avoid hardship.

3. The Board will proceed to obtain the evidence necessary to reach a decision on the claim as soon as possible.
4. Health care benefit bills will not be paid under a preliminary determination. Where a preliminary determination has been made on a claim and there has been a request for surgery, it will be handled in the same manner as with other claims that have yet to be formally adjudicated. In such cases, the patient and physician should proceed privately, pending a decision on the claim. This principle also applies with respect to other medical referrals, with the exception of a consultation with a specialist that may be paid on an investigation basis.
5. Where a preliminary determination has been made on a claim and wage loss payments have commenced, and subsequently a decision is made to disallow the claim, then:
  - (a) no recovery of the payments will be made in the absence of fraud or misrepresentation;
  - (b) the employer's sector or rate group will be relieved of the cost of any unrecovered payments pursuant to policy item #113.10.

The above rules governing preliminary determinations apply to applications to reopen a previous claim as well as applications commencing new claims.

A preliminary determination made in accordance with this policy is not a "decision" for the purposes of section 96(5). Rather, it is a Board administrative action that is intended to provide temporary financial relief to the worker until the Board receives the information required in order to make a decision on the validity of a claim. However, once the Board receives the required information and makes a decision, that decision is subject to the provisions of section 96(5).

**EFFECTIVE DATE:** June 1, 2009 – Delete references to Board officer.  
**HISTORY:** March 3, 2003 – Amendments to clarify that a preliminary determination is made to provide temporary financial relief until the Board receives information. Addition of requirement that an application for compensation must have been received. Amendments substitute the term "preliminary determination" for "interim decision". Addition of statements discussing the application of

section 96(5). Policy applies to all preliminary determinations made on or after March 3, 2003.

**APPLICATION:** Applies on or after June 1, 2009

### **#96.22**      *Suspension of Claim*

Where a report is submitted to the Board simply for the record, and where the worker did not receive medical treatment or was not disabled from work, or no other costs were incurred, no adjudication is necessary and the file will simply be marked "nothing to consider".

Where information necessary to the adjudication of a claim can only be provided by the worker, and the worker ignores a request for that information, refuses to provide it or hampers the investigation, the claim may be suspended (see policy item #93.26 regarding a worker's obligation to provide information).

Where a claim file is opened, and it is later established that the claim will be fully administered and paid by another Board under the terms of the Interjurisdictional Agreement, the British Columbia file will be placed in suspense. (20)

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

- (1) where the worker leaves the province without notifying the Board or receiving prior consent from the Board; (21)
- (2) where the worker is being paid full salary by the Federal Government; (22)
- (3) where the worker refuses to accept the cheques;
- (4) where a worker moves and the worker's whereabouts are unknown.

Where a claim has been suspended, all parties are notified of this fact and of the reasons for it. This includes any party from whom an account has been received. When the information required has been received or any other ground which gave rise to the suspension has been removed, the suspension will be lifted. In that event, the parties involved will again be notified.

### **#96.30**      **Disability Awards Decision-Making Procedures**

The Board determines whether an actual or potential permanent disability is accepted on a claim.

Where the Board has accepted an actual or potential permanent disability, the Board then determines the extent of the disability, and calculates the worker's permanent disability award entitlement.

In cases of minor disabilities, the Board may calculate the award without the benefit of a medical examination if this is considered unnecessary having regard to the medical evidence already on the claim. Except for those cases, the normal practice is for a section 23(1) assessment to be conducted for disability awards purposes by the Board or an authorized External Service Provider (see policy item #39.01).

Although the evaluation is not the only medical evidence that the Board may use, it will usually be the primary input.

The decision-making procedure for assessing entitlement to a permanent disability award for psychological impairment is discussed in policy item #39.01.

In those cases where the worker has a section 23(1) assessment, the Board is required to notify the worker indicating the results of the evaluation and the conclusions reached regarding the question of permanent disability award entitlement.

The final decision on the assessment of a permanent disability award under section 23(3) is made by the Disability Awards Committee.

Requests for the commutation of permanent disability awards are adjudicated by the Board. Before making a decision, it may be necessary to obtain vocational rehabilitation input.

**EFFECTIVE DATE:** June 1, 2009 – Insert reference that a Board officer determines whether an actual or potential disability is accepted on the claim. Delete references to Board officer in Disability Awards, Medical Services and Consultant.

**HISTORY:** October 1, 2007 – Revised to delete references to memos and memorandums.  
July 2, 2004 – Revisions to the role of Board officers applied to all decisions, including appellate decisions, made on or after July 2, 2004.

**APPLICATION:** Applies on or after June 1, 2009.

## **#97.00 EVIDENCE**

Under the old English system, which was an adversary system of workers' compensation, there was a burden of proof imposed on the worker, but that is not the correct practice here. The Board must not start with any presumption against the worker, but neither must there be any presumption in the worker's favour. The correct approach is to examine the evidence to see whether it is sufficiently complete and reliable to arrive at a sound conclusion with confidence. If not, the Board should consider what other evidence might be obtained, and must take the initiative in seeking further evidence. After that has been done, if, on weighing the available evidence, there is then a preponderance in favour of one view over the other, that is the conclusion that must be reached. But if it appears upon the weighing of the evidence that the disputed possibilities are evenly balanced then the rule comes into play which requires that the issue be resolved in accordance with that possibility which is favourable to the worker.

Although there is no burden of proof on the worker, the *Act* contains prerequisites for benefits. Compensation will not be paid simply because, for example, a telephone call is received from someone claiming to be a worker, who has been hurt, and was disabled for a certain number of days. Some basic evidence must be submitted by the worker to show that there is a proper claim. The extent of that basic evidence necessary, and the weight to be attached to it, is entirely in the hands of the Board.

It is therefore not uncommon to see that a claim will be denied when a worker, away from employment, begins to feel some pain and discomfort in the lower back, and seeking to find a reason for this condition, thinks back to the work being done over a period of time and concludes that the problem must have resulted from something which occurred on a certain day when certain heavy work was being performed. The question then arises whether there was anything other than the worker's hindsight which would allow the Board to conclude that the work done some weeks or months previously had causative significance. It is at this point that investigation takes place and the evidence is weighed. If there is nothing objective to indicate any activity at work was potentially causative of the condition complained of, at or near the time alleged by the worker, it can fairly be said that the claim has not been established. The worker has simply failed to present those fundamental facts which bring the provisions of the *Act* into play.

**EFFECTIVE DATE:** June 1, 2009 – Delete references to officer and Adjudicator.

**APPLICATION:** Applies on or after June 1, 2009

## #97.10 Evidence Evenly Weighted

Complaints are sometimes received at the Board that a worker has not been given the benefit of the doubt. Usually, these complaints relate to a situation in which the worker has a disability, but the issue is whether it is one arising out of or in the course of employment. The essence of the complaint is often that if there is some possibility that the injury arose out of the employment, the worker should be given the benefit of the doubt. For the Board to take that view, however, would be inconsistent with the terms of the *Act*. Where it appears from the evidence that two conclusions are possible, but that one is more likely than the other, the Board must decide the matter in accordance with that possibility that is more likely.

Under the terms of section 99(3), the Board is required to decide an issue in accordance with the possibility which is favourable to the worker where it appears that “the evidence supporting different findings on an issue is evenly weighted in that case”. This applies only where there is evidence of roughly equal weight for and against the claim. It does not come into play where the evidence indicates that one possibility is more likely than the other. (23)

While an absence of positive data does not necessarily mean that a condition is not related to a person’s employment, it may mean that there is a lack of evidence that any such relationship exists. The Board, as a quasi-judicial body, must make its decisions according to the evidence or lack of evidence received, not in accordance with speculations unsupported by evidence. Section 99(3) of the *Act* applies when “the evidence supporting different findings on an issue is evenly weighted in that case.” However, if the Board has no evidence before it that a particular condition can result from a worker’s employment, there is no doubt on the issue; the Board’s only possible decision is to deny the claim. If one speculates as to the cause of a condition of unknown origin, one might attribute it to the person’s work or to any other cause, and one speculated cause is no doubt just as tenable as any other. However, the Board can only be concerned with possibilities for which there is evidential support and only when the evidence is evenly weighted does section 99(3) apply.

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

## #97.20 Presumptions

There are three statutory presumptions in favour of workers or dependants which have already been discussed in earlier chapters. These are as follows:

- (1) In cases where the injury is caused by accident, where the accident arose out of the employment, unless the contrary is shown, it shall

be presumed that it occurred in the course of the employment; and where the accident occurred in the course of the employment, unless the contrary is shown, it shall be presumed that it arose out of the employment. (24)

- (2) If the worker at or immediately before the date of disablement was employed in a process or industry mentioned in the second column of Schedule B, and the disease contracted is the disease in the first column of the schedule set opposite to the description of the process, the disease shall be deemed to have been due to the nature of that employment unless the contrary is proved. (25)
- (3) Where a deceased worker was, at the date of death, under the age of 70 years and suffering from an occupational disease of a type that impairs the capacity or function of the lungs, and where the death was caused by some ailment or impairment of the lungs or heart of non-traumatic origin, it shall be conclusively presumed that the death resulted from the occupational disease. (26)

The *Act* contains no general presumption either in favour of the worker or against the claim.

### **#97.30 Medical Evidence**

It is the responsibility of the Board to make all the decisions relating to the validity of a claim and to make all the decisions relating to compensation payments. This includes decisions relating to medical as well as other aspects of the claim.

This does not mean, of course, that a lay judgment is preferred to a medical opinion on a question of medical expertise. What it means is that the Board is responsible for the decision-making process, and for reaching the conclusions on the claim. But this will, of course, require an input of medical evidence, or sometimes other expert advice, on any issue requiring professional expertise.

In reaching conclusions on a medical question, the guide-rules are set out below.

**EFFECTIVE DATE:** June 1, 2009 – Delete references to Claims Adjudicator, Claims Officer, the Disability Awards Officer and the Adjudicator in Disability Awards.

**APPLICATION:** Applies on or after June 1, 2009

### **#97.31 Matter Requiring Medical Expertise**

Where the matter is one requiring medical expertise, the decision must be preceded by a consideration of medical evidence (this term includes medical

opinion or advice). Medical evidence might consist of a statement in the Form 8 Physician's First Report, (27) or some information or opinion from the attending physician, or it might consist of advice provided from a Board Medical Advisor or another doctor. It is for the Board to decide when medical evidence is needed, what kind of medical evidence is needed, and on what questions.

**EFFECTIVE DATE:** June 1, 2009 – Delete references to Claims Adjudicator and Claims Officer.  
**APPLICATION:** Applies on or after June 1, 2009

### **#97.32**      *Statement of Worker about His or Her Own Condition*

A statement of a worker about his or her own condition is evidence insofar as it relates to matters that would be within the worker's knowledge, and it should not be rejected simply by reference to an assumption that it must be biased. Also, there is no requirement that the statement of a worker about his or her own condition must be corroborated. The absence of corroboration is, however, a ground for considering whether the worker should be interviewed by the Board, or telephone enquiries made, or whether anything relevant could be discovered by having the worker medically examined. A conclusion against the statement of the worker about his or her own condition may be reached if the conclusion rests on a substantial foundation, such as clinical findings, other medical or non-medical evidence, or serious weakness demonstrated by questioning the worker, or if the statement of the worker relates to a matter that could not possibly be within his or her knowledge.

**EFFECTIVE DATE:** June 1, 2009 – Delete references to Claims Adjudicator, Claims Officer and Board Medical Advisor.  
**APPLICATION:** Applies on or after June 1, 2009

### **#97.33**      *Statement by Lay Witness on Medical Question*

A statement by a lay witness on a medical question may be considered as evidence if it relates to matters recognizable by a layperson; but not if it relates to matters that can only be determined by expertise in medical science. For example, a statement by a fellow worker that he or she saw the worker suffering from silicosis would be worthless; but a statement by a fellow worker reporting to have seen the worker bleeding from the forehead would be evidence of a head wound. Statements made by a first aid attendant or other categories of paramedical personnel can be considered insofar as they relate to matters within the normal experience or training of that category of paramedical personnel. But they must obviously be treated very cautiously if they go beyond that into areas requiring greater medical expertise, or if they conflict with the opinion of a doctor.

## #97.34 *Conflict of Medical Opinion*

Where there are differences of opinion among doctors, or other conflicts of medical evidence, the Board must select from among them. The Board must not do it by automatically preferring the opinions of one category of doctors to another category, nor should it be done by counting heads, so many opinions one way and so many another. The Board must analyze the opinions and conflicts as best as possible on each issue and arrive at her or his own conclusions about where the preponderance of the evidence lies. If it is concluded that there is doubt on any issue, and that the evidence supporting different findings on an issue is evenly weighted in that case, the Board must follow the mandate of section 99 and resolve that issue in a manner that favours the worker. (28)

It should never be assumed that there is a conflict of medical opinion simply because the opinions of different doctors indicate different conclusions. A difference in conclusion between doctors may or may not result from a difference in medical opinion. For example, the difference could result from different assumptions of non-medical fact. Where there are two or more medical reports or memos on file from physicians, indicating different conclusions, the Board will not simply select among them as a first step. The Board should first think about why they are different and consider whether the relevant non-medical facts have been clearly established. The Board may seek advice to determine whether the best medical evidence has been obtained and, for example, find out if any appropriate medical procedures can be instituted that would assist in arriving at a more definite conclusion.

Where two or more medical reports or memos indicate a probable difference of medical opinion and the issue is serious, the matter will normally be discussed with the physicians involved.

The Board has no rule that states that the evidence of a physician is always to be preferred to that of a chiropractor or other qualified practitioner. Reports from both types of practitioner are acceptable evidence and are weighed on their merits. This principle applies even if the referral to the practitioner is contrary to Board policy. Should there, for example, be concurrent treatment by a physician and a chiropractor, the Board might not pay for the chiropractor, but any chiropractor reports received must be weighed as evidence. They are not ignored just because the referral was unauthorized. (29)

**EFFECTIVE DATE:** June 1, 2009 – Delete references to officers.  
**HISTORY:** March 3, 2003 – Insert new wording of section 99.  
**APPLICATION:** Applies on or after June 1, 2009.

## #97.35 *Termination of Benefits*

Where a treating physician expresses an opinion that a worker is disabled from work by reason of a compensable disability, the Board may rely upon overall existing medical evidence from a doctor who has examined the worker or other substantive evidence on the file to reach a conclusion contrary to that opinion or may decide to carry out further investigation which may involve a Board medical examination.

**EFFECTIVE DATE:** June 1, 2009 – Delete references to Claims Adjudicator, Claims Officer and Board physician.  
**APPLICATION:** Applies on or after June 1, 2009

## #97.40 **Disability Awards**

In cases of very minor disabilities, the Board may proceed to calculate a disability award without a section 23(1) evaluation, if it is unnecessary having regard to the medical evidence already available. Except for those cases, the normal practice is for a section 23(1) evaluation to be conducted for disability awards purposes by the Board or an External Service Provider.

It is the responsibility of the Board to classify the disability as a percentage of total disability. In doing this, it is proper for the Board to consider other factual and medical evidence as well as the section 23(1) evaluation report prepared by the Board or the External Service Provider. However, although the report of the Board or the External Service Provider is not the only medical input that the Board may use, it will usually be the primary input, and caution will be used in referring to any other medical opinion.

The section 23(1) evaluation report takes the form of expert evidence which, in the absence of other expert evidence to the contrary, should not be disregarded. This does not mean that the Board must adopt the percentage indicated by the section 23(1) evaluation. It is always open to the Board to conclude that, although the functional impairment of the worker is a certain percentage, the disability (i.e. the extent to which that impairment affects the worker's ability to earn a living) is greater or less than the percentage of impairment.

The decision-making procedure for assessing entitlement to a permanent disability award for psychological impairment under section 23(1) of the *Act* is discussed in policy item #39.01.

In making a determination under section 23(1), the Board will enquire carefully into all of the circumstances of a worker's condition resulting from a compensable injury.

**EFFECTIVE DATE:** June 1, 2009 – Delete references to officers in Disability Awards and officer.  
**HISTORY:** January 1, 2003 – References to prior Subjective Complaints policy removed. Applies to new claims received and all active claims that are currently awaiting an initial adjudication.  
**APPLICATION:** Applies on or after June 1, 2009.

### **#97.50 Rumours and Hearsay**

Hearsay must only be used very cautiously as evidence, and rumour must not be used as evidence at all. But even rumour is often valuable as a lead to investigation.

### **#97.60 Lies**

A lie may be ground for drawing an adverse inference with regard to the facts to which it relates. But it is not in itself ground for denying compensation, particularly when it relates to something not relevant to the claim at all.

## **#98.00 INVESTIGATION OF CLAIMS**

In the majority of claims the issues are decided by reference to the information received in the worker's application and the employer's and medical reports. Any insufficiency in the information is usually made good by telephone, correspondence, or by informal interview. In a minority of claims, a more formal inquiry, or medical examination, may be necessary.

### **#98.10 Powers of the Board**

Section 87 of the *Act* provides as follows:

- (1) The Board has the like powers as the Supreme Court to compel the attendance of witnesses and examine them under oath, and to compel the production and inspection of books, papers, documents and things.
- (2) The Board may cause depositions of witnesses residing in or out of the Province to be taken before a person appointed by the Board in a similar manner to that prescribed by the Rules of the Supreme

Court for the taking of like depositions in that court before a commissioner.

Usually, the Board receives the willing cooperation of all concerned, and the power of subpoena is not used as a normal routine.

**EFFECTIVE DATE:** March 3, 2003 (as to new wording of section 87)  
**APPLICATION:** Not applicable.

### *#98.11 Powers of Officers of the Board*

Section 88(1) provides that “The Board may act on the report of any of its officers, and any inquiry which it is considered necessary to make may be made by an officer of the Board or some other person appointed to make the inquiry, and the Board may act on his or her report as to the result of the inquiry.”

The officer and every other person appointed to make an inquiry has for the purposes of an inquiry under subsection (1) all the powers conferred upon the Board by section 87. (30)

Every officer or person authorized by the Board to make examination or inquiry under this section may require and take affidavits, affirmations or declarations as to any matter of the examination or inquiry, and take affidavits for the purposes of this *Act*, and in all those cases to administer oaths, affirmations, and declarations and certify that they were made. (31)

The Board has ruled that, for the purpose of section 88, employees of the Board, who, in the performance of their prescribed duties, do those things which are reserved to be done by an officer of the Board, are, and have been, for matters arising out of Part 1 of the *Act*, appointed officers of the Board.

**EFFECTIVE DATE:** March 3, 2003 (as to new wording of section 88)  
**APPLICATION:** Not applicable.

### *#98.12 Examination of Books and Accounts of Employer*

Section 88(3) provides that “The board, an officer of the board or a person authorized by it for that purpose, may examine the books and accounts of every employer and make any other inquiry the board considers necessary to ascertain . . . whether an industry or person is within the scope of this Part. For the purpose of the examination or inquiry, the board or person authorized to make the examination or inquiry may give to the employer or the employer's agent notice in writing requiring the employer to bring or produce before the board or person, at a place and time to be mentioned in the notice, which time must be at least 10 days after the giving of the notice, all documents, writings, books, deeds

and papers in the possession, custody or power of the employer touching or in any way relating to or concerning the subject matter of the examination or inquiry referred to in the notice, and every employer and every agent of the employer named in and served with the notice must produce at the time and place required all documents, writings, books, deeds and papers according to the tenor of the notice.”

An employer and every other person who obstructs or hinders the making of an examination or inquiry mentioned in subsection (3), or who refuses to permit it to be made, or who neglects or refuses to produce the documents, writings, books, deeds, and papers at the place and time stated in the notice mentioned in Subsection (3), commits an offence. (32) The maximum fine for committing this offence is set out in Appendix 6.

### **#98.13**      *Medical Examinations and Opinions*

The authority of the Board to require a worker to be medically examined is dealt with in policy item #78.20.

The medical resources of the Board cannot be used to provide a medical opinion to anyone on request. The Board will, therefore, decline to provide a medical opinion if the request does not come from someone authorized to make the request. Those authorized are Board staff whose duties require an input of medical advice.

A Workers’ Adviser and an Employers’ Adviser have access to medical opinions already on file, but have no right to require any further medical opinions to be produced.

**EFFECTIVE DATE:**            June 1, 2009 – Delete references to Medical Advisors and officers.  
**HISTORY:**                      March 3, 2003 – Deletion of references to Review Division and Appeal Division.  
**APPLICATION:**                Applies on or after June 1, 2009

### **#98.20**      **Conduct of Inquiries**

The Board operates on an inquiry as opposed to an adversary system. It does not, like a court operating under the adversary system, decide between the arguments and evidence submitted by two opposing parties at a hearing and limit itself to the material presented at that hearing. While the judge under the adversary system has little or no authority to carry out investigations, the Board is obliged by section 96 of the *Act* both to investigate and to adjudicate claims for compensation. Oral hearings or interviews are not always conducted before a decision is reached and, when they are conducted, provide only part of the

information relied on by the Board. The other written reports on the file will also be considered. Such hearings are informal in nature and not subject to the formal rules of evidence and procedure followed in court hearings.

### **#98.21**      *Place of Inquiry*

For the purposes of claims adjudication, an officer of the Board may enter premises and make such inspections as considered necessary, notwithstanding that another agency may have inspection jurisdiction for accident prevention purposes. Where an inspection is of a technical nature and can only be carried out by someone technically qualified, perhaps an Occupational Hygiene Officer, such technical personnel may be used to make an inspection for the purposes of claims adjudication.

Where appropriate, the worker should be offered the opportunity to accompany the Board officer on the workplace visit.

**EFFECTIVE DATE:**            June 1, 2009 – Delete references to Adjudicators and Claims Adjudicators.

**APPLICATION:**                Applies on or after June 1, 2009

### **#98.22**      *Failure of Worker to Appear*

If the worker fails or refuses to appear at an inquiry, her or his claim may be suspended, or decided in her or his absence, or a further appointment may be arranged.

### **#98.23**      *Representation*

A worker has a right to bring a representative to any enquiry, both at first instance and on appeal.

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

### **#98.24**      *Presence of Employer*

If a worker is unrepresented, and the employer or employer's representative appears, it must be determined whether the employer is appearing on behalf of the worker. If the employer is appearing on behalf of the worker, the worker will be asked (but not in the presence of the employer) whether he or she has any objection to the employer being present. If there is no objection, the employer can be invited to attend the interview. If the worker does object, the employer will be asked to wait outside, and can be interviewed separately.

If appearing against the worker, the employer is not allowed to be present at the interview with the worker and must be interviewed separately. If there is any doubt as to the employer's intentions, the employer will be interviewed separately.

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

### **#98.25**      *Oaths*

The oath is not administered as a normal routine in every inquiry, but is used when considered appropriate.

If:

1. a person called to give evidence objects to taking an oath, or is objected to as incompetent to take an oath, and the Board is satisfied of the sincerity of the objection of the witness from conscientious motives to be sworn or that the taking of an oath would have no binding effect on his or her conscience;
2. or the Board is satisfied that the form of oath which a person called to give evidence declares to have a binding effect on his or her conscience is not such that it can be taken in the place where the inquiry is being held, or that it is not fitting so to do, and the Board so directs,

the person shall, instead of taking an oath, make an affirmation. (33) An employer or representative or a worker's representative need not be placed under oath unless they have something specific or pertinent to contribute to the inquiry.

### **#98.26**      *Witnesses and Other Evidence*

A worker may bring to an inquiry such witnesses, and may submit such verbal and documentary evidence, as she or he thinks will be of assistance.

Wherever possible, witnesses will be interviewed separately without the worker being present. They will not be present while the worker is being interviewed.

### **#98.27**      *Cross-examination*

Under the inquiry system (contrary to the adversary system), there is no right of cross-examination of the parties or witnesses. If, in the process of an inquiry, one of the parties wishes to ask a question of the person whose evidence is

being taken, the question should be referred to the interviewer conducting the inquiry who, in turn, can relay the question if it is felt it would be helpful.

Cross-examination may, however, sometimes be permitted.

## **#99.00 DISCLOSURE OF INFORMATION**

The Board, for the purposes of administering the *Act*, collects and maintains information for the purpose of adjudication and managing claims for workers or their dependants. In order to carry out all aspects of this activity, the Board in a variety of situations discloses information contained in claim files.

Provincial legislation, known as *Freedom of Information and Protection of Privacy Act* ("*FIPPA*") provides access for the public to the information maintained by the Board while at the same time protecting personal privacy.

*FIPPA* differentiates among "personal information", information relating to third party business interests and other types of information in the possession of a Public Body such as the Board. Personal information means recorded information about an identifiable individual.

Freedom of information and protection of privacy can be competing principles in many situations. Which principle is to be paramount in any particular case is sometimes difficult to determine. Until advised otherwise by the Information and Privacy Commissioner appointed under section 37 of *FIPPA* openness prevails as far as possible in the area of compensation services. Exceptions to access should be narrowly construed. Since claim files deal with an identifiable individual, they contain personal and sensitive information. The privacy provisions of *FIPPA* will, therefore, prevail other than for the specific exceptions contained in *FIPPA*. Examples of such exceptions include the rights in section 3(2) of a party to a proceeding to access information, or the variety of exceptions listed in sections 33.1 and 33.2 such as the need to comply with the requirements of a specific *Act*. The *Act* requires a copy of records related to a matter under review or appeal to be provided to the parties to a review or appeal.

Section 3(2) of *FIPPA* states that the *Act* does not limit the information available by law to a party to a proceeding. A proceeding does not take place until either the worker or the employer has initiated a formal review or appeal.

Before a review or appeal is initiated, the Board must apply *FIPPA* to requests for claim information. Before a review or appeal is initiated, an employer is not entitled to a copy of the worker's claim file. Disclosure to an employer in such circumstances, is limited to that information necessary for the adjudication or administration of the claim, that is on a "need to know" basis. Once a review or appeal has been initiated, full disclosure is available to either a worker or an

employer. These disclosure rules are considered to be in accordance with *FIPPA* and the rules of natural justice.

Requests for disclosure for information in a situation not covered by the policies in this Manual should be directed to the FIPP Department of the Board. These requests will be considered on an individual basis in accordance with *FIPPA*.

### *Dispute Resolution*

A request for a review of the FIPP Department's decision by the Information and Privacy Commissioner may be made within 30 days of the date the person asking for the review is notified of the latest decision.

The Chair of the board of directors has ultimate responsibility within the Board for implementation of *FIPPA* for the purposes of workers' compensation.

<b>EFFECTIVE DATE:</b>	June 1, 2009 – Delete references to Manager and Service Delivery Locations.
<b>HISTORY:</b>	March 3, 2003 – Reference to the provision of copies of records related to a matter under review or appeal.
<b>APPLICATION:</b>	Applies on or after June 1, 2009

## **#99.10 Disclosure of Issues Prior to Adjudication**

Where a claim is protested by an employer, the Board is required to investigate the matter. In most cases this investigation involves contact with the worker. Normally, most workers at that time become aware of the protest. In some situations a protested claim may be quickly resolved and the claim accepted. In such cases workers may not be aware of the protest.

As part of the investigation which precedes a decision to disallow a claim, the Board in virtually every case will have communicated with the worker. These communications may be by telephone, in person or in writing. Through the medium of these communications the worker is made aware of the nature of the problem and has an opportunity for input and comment. If, however, for some reason the Board concludes that a claim may not be acceptable, the worker is contacted before a decision is reached. The contact provides the worker with an opportunity for input and comment. In situations involving serious cases or complex issues where no prior contact has been made with the worker, the details should be communicated in writing. Where this is done, the possibility of obtaining assistance from a union official or other adviser may be brought to the worker's attention.

Written authorization is required in order to release information to any advocate, representative or other person designated by the worker or employer. Once received, the Board will cooperate with and notify workers' or employers'

advocates or representatives of any decisions which have been made and communicated to the worker or employer.

Where an employer has protested a claim which, upon investigation, appears to be valid, the Board should, before making the decision, phone the employer to ensure that the employer is aware of the issues relevant to the protest and has an opportunity to comment.

**EFFECTIVE DATE:** June 1, 2009 – Delete references to Adjudicator.

**HISTORY:** January 1, 2005 – Housekeeping amendment to require written authorization for disclosure.

**APPLICATION:** Applies on or after June 1, 2009

## **#99.20 Notification of Decisions**

### **1. Definitions**

A “decision” is a determination of the Board to award, deny, reconsider or limit entitlement to benefits and services, or impose or relieve an obligation, pertaining to compensation or rehabilitation matters under Part 1 of the *Act* or policy.

An “affected person” is a worker, employer or a deceased worker’s dependant, or a person who claims to be an affected person, who is directly affected by a decision and may request a review or appeal of that decision.

### **2. Communicating Decisions**

A decision is made, for the purpose of triggering the timelines for reconsiderations and reviews, on the date the decision is communicated to the affected person.

If the decision is communicated to affected persons on different dates, the statutory timelines commence on the date the decision is first communicated to an affected person.

The Board also communicates decisions to an affected person’s advocate or representative if valid authorization is in place.

In occupational disease claims, where there are a number of different employers identified, but none of the employers are responsible for 20% of the exposure or more, decision letters and review and/or appeal information are sent to the employers’ association that best represents the appropriate sector and rate group of that industry.

## **A. Written Communication**

The Board will communicate the following decisions through a decision letter:

- Decisions on whether a claim is accepted, denied or rejected;
- Decisions on initial entitlement to temporary disability benefits, a permanent disability award, benefits for a fatality and vocational rehabilitation assistance;
- Decisions on initial and long-term average earnings;
- Decisions that deny or limit benefits to a worker;
- Decisions regarding the re-opening of a matter previously decided;
- Decisions resulting from the reconsideration process;
- Decisions regarding the acceptance of a compensable consequence;
- Decisions that have been protested by the employer; and
- Decisions on whether an employer may be granted a relief of costs.

The communication of the above decisions in writing triggers the timelines for reconsideration and review. The fact that a decision was not communicated in writing does not void the decision.

If one of the above decisions is not communicated in writing, the Board will determine whether the decision was satisfactorily communicated through other means, for example, verbally, through the payment or termination of compensation, or the referral of a worker for medical treatment or examination, in order to determine the timelines for reconsideration and review.

A decision letter will include an explanation of the relevant rights of review and/or appeal, and should, where appropriate, include the following elements:

1. The matter being adjudicated;
2. The evidence that was considered;
3. An explanation of the weight apportioned to the evidence and the reasons for the weighting;
4. Review of on-going communication with the worker where the relevant issues were discussed and details of the worker's response.

5. Reference to any relevant sections of the *Act* or Board policy;
6. The formal decision; and
7. An explanation of the impact of the decision on payment of compensation or entitlement to other benefits or services.

Decision letters are provided to persons directly affected by the decision.

Before a review or appeal is initiated, the type of information from a worker's claim that can be disclosed to the employer and/or authorized advocates and representatives is limited. Disclosure of personal and medical information is limited to information that is relevant to the claim and the issues involved, and that the employer has a need to know. The same approach applies for notification of decisions to healthcare providers, such as physicians and pharmacists.

Where a decision is provided in writing and mailed to an affected person, the decision is deemed to have been communicated on the 8th day after it was mailed. Therefore, the reconsideration timeline starts at the end of the 8-day mailing period.

## **B. Verbal and Other Communication**

The Board may also communicate decisions such as health care decisions or administrative actions, verbally. Examples of the types of decisions the Board may communicate verbally include:

- a decision to award an additional two weeks of physiotherapy benefits beyond the initial entitlement period; or
- a referral to a specialist.

When a decision is communicated verbally, an explanation of the rights of review and/or appeal will be verbally provided to the affected person. The verbal communication also should, where appropriate, include an explanation of the decision in accordance with the elements of a decision letter.

Documentation on the claim is sufficient evidence that verbal communication of the decision, including the reasons for the decision and notice of review and appeal rights, has occurred.

A copy of the written record of the decision is provided upon request following the verbal communication of a decision; however, it does not constitute a new decision. The statutory timelines for reconsiderations and reviews commence from the date of the verbal communication.

The Board may communicate decisions through the ongoing payment of temporary or permanent disability benefits, the payment of health care invoices, or the final payment of temporary disability or health care benefits, where the decision is uncontested and/or is in favour of the worker.

For example, where a claim is allowed for ongoing wage-loss benefits and there has been no protest from the employer, the Board does not provide a letter outlining the reasons for the continued payment of benefits.

### **3. Finding of Facts**

A finding of fact is not a decision. It is the factual basis on which a decision is made.

Findings of fact may change based on new information and are not subject to the 75-day time limit on the Board's reconsideration authority.

A finding of fact may not be reviewed or appealed in the absence of an expressed or implied decision under review or appeal.

### **4. Rejected Claims**

The term "reject" is different than a "disallow" and refers to a claim where:

1. a self-employed worker has no personal optional protection;
2. the worker was employed by an employer not covered under the *Act*;
3. a report was submitted in error. Normally, this occurs when a physician, on the basis of a misunderstanding, submits a report in error.

If a claim is rejected, notification of the review and/or appeal procedures is provided to the person making the claim.

<b>EFFECTIVE DATE:</b>	April 1, 2010
<b>HISTORY:</b>	June 1, 2009 – Delete reference to send a cheque and replace with may make a payment. January 1, 2005 – Housekeeping amendment to require written authorization for disclosure, and to clarify appropriate disclosure principles. March 3, 2003 – Insert references to evenly weighted evidence and the rights of review and/or appeal.
<b>APPLICATION:</b>	Applies to all decisions made on or after April 1, 2010

## #99.22 *Procedure for Handling Complaints or Inquiries About a Decision*

The Board frequently receives letters, telephone calls and visits from workers, employers and their representatives concerning the decisions they make on claims. Generally, the party in question will be either asking for further explanation of the decision or expressing dissatisfaction with the substance of the decision.

Where the worker or employer is requesting further explanation, this should be given. In the case of advocates and representatives, disclosure of information will only be provided where proper written authorization is in place. Where, however, dissatisfaction is expressed with the substance of the decision, the procedure outlined in C14-103.01 is followed. This procedure is intended only to cover situations where the worker, employer or representative is dissatisfied with the substance of a decision on a claim. It is not intended to cover complaints concerning the general administration of the claim, for example, delays in processing.

At no time is a letter expressing dissatisfaction with the substance of a decision to be simply committed to the claim with no further action taken.

<b>EFFECTIVE DATE:</b>	June 1, 2009 – Delete references to officers and manager in the Compensation Services Division.
<b>HISTORY:</b>	January 1, 2005 – Housekeeping amendment to require written authorization for disclosure of information. March 3, 2003 – Insert reference to C14-103.01 and delete references to Review Board.
<b>APPLICATION:</b>	Applies on or after June 1, 2009

## #99.23 *Unsolicited Information*

Unsolicited information will not be placed on the worker's claim until it has been assessed for relevancy and accuracy.

Where the Board receives unsolicited information about a worker, the following principles apply:

1. Unsolicited information that is clearly irrelevant to the administration of the worker's claim will be destroyed.
2. Unsolicited information that appears to be relevant or potentially relevant to the administration of the worker's claim will be investigated for accuracy.

3. Where, after investigation, the information is determined to be inaccurate or its accuracy is unknown, the information will be destroyed, including any record that initiated the investigation, the investigation report and any documentation obtained in connection with the investigation.
4. Where, after investigation, the information is determined to be accurate, a final assessment as to relevancy will be made.
5. Where accurate information is considered to be irrelevant to the administration of the worker's claim, the information will be destroyed, including any record that initiated the investigation, the investigation report and any documentation obtained in connection with the investigation.
6. Where accurate information is considered to be relevant or potentially relevant to the administration of the worker's claim, the information is placed on the worker's claim as follows:
  - (a) anonymous information — The investigation report and any documentation obtained in connection with the investigation will be placed on the claim. The record that initiated the investigation will be destroyed and the claim will state that the investigation was initiated on the basis of information received.
  - (b) information from identified source — The record that initiated the investigation, the investigation report and any documentation obtained in connection with the investigation will be placed on the claim.

An identified source will be advised that the information may be disclosed to the worker. If the identified source wishes to become anonymous at any time, the information will be treated as anonymous information under (a) above. If the identified source wishes to remain identified, this will be recorded on the worker's claim.

7. If only some of the information is accurate and only some of the accurate information is relevant or potentially relevant to the administration of the worker's claim, the record that initiated the investigation will be destroyed and reference will only be made on the worker's claim to information that is both accurate and relevant or potentially relevant.
8. If, during the investigation, accurate information is discovered that is unrelated to the subject matter of the unsolicited information, but

is relevant to the administration of the worker's claim, that information will be recorded separately on the worker's claim.

9. Where unsolicited information is found to be accurate and relevant or potentially relevant to the administration of the worker's claim, the worker will be advised of the information and given an opportunity to comment. Complaints about the accuracy and relevancy of unsolicited information will be dealt with according to policy item #99.35 - Complaints Regarding File Contents.

### **#99.24 Notification of Permanent Disability Awards**

When a permanent disability award is granted, the letter advising of the award will include the permanent functional impairment evaluation report on which the award has been based. It will also contain the percentage rate of disability assessed. Where the case is one of Proportionate Entitlement, the letter will state the nature and extent of the pre-existing disability and the nature and extent of the further disability. A copy of the letter is sent to the employer. This letter will include information regarding the relevant rights of review and/or appeal.

Other than to the employer or the worker, the amount being paid per month for a permanent disability award will only be disclosed to public or private agencies in accordance with the criteria for disclosure as set out in policy item #99.50.

The amount of the capital reserve is disclosed to the employer when notified of the award. The reserve amounts will be given to the worker on request.

**EFFECTIVE DATE:** March 3, 2003 (as to references to review and appeal)

**APPLICATION:** Not applicable.

### **#99.30 Disclosure of Claim Files**

The claim file is the master file for recording information used in the adjudication and administration of a claim. Information may exist outside of the claim file. However, all evidence used in the adjudication of the claim is contained in the claim file. Medical opinions, as well as any further comments, are all recorded on, and become part of, the claim file.

Sensitive personal information that is received, which has not been specifically requested and which is not relevant to the adjudication or administration of the claim will not become part of the claim file. It will normally be destroyed. However, where the original document is still in the Board's possession, it will be returned to the sender when requested by the worker or sender.

Discretion is necessary in documenting the file to ensure that rumour or innuendo is not mistakenly reported as fact where it is unsupported or cannot be verified. Comments regarding claimants, employers and other persons involved in the claim are confined to relevant matters which have been observed personally or for which there is other supporting evidence. Observations should be confined to the particular circumstances of the claim or other matter and should not make general comments about an individual's personality. Comments should be worded in the least offensive way possible and avoid derogatory terms.

In recognition of the sensitive nature of sexual assault claims where the employer is alleged to be the perpetrator of the assault, all such cases, regardless of the residence of the worker, are assigned to the Sensitive Claims Area. Disclosure of these claim files for review or appeal and other legal purposes is administered by the Sensitive Claims Area.

**EFFECTIVE DATE:** June 1, 2009 – Delete references to Adjudicator, Board officers, physicians, Board Medical Advisers, Manager and Board staff.  
**HISTORY:** March 3, 2003 – Insert reference to review.  
**APPLICATION:** Applies on or after June 1, 2009

### **#99.31**      *Eligibility for Disclosure*

Disclosure of their claim files is provided to a worker or dependant on request. Only one copy is provided and no fee is charged for this disclosure.

After a review or appeal has been initiated, an employer may obtain disclosure. An employer may obtain disclosure even though the worker has not requested disclosure.

Disclosure will be provided to the representative of the employer or worker if authorized in writing.

Where there is a valid review or appeal in process regarding a matter arising under a claim to which another claim is also relevant, disclosure to the employer will also be allowed of the other claim. However, there must be a request for disclosure of that particular claim. The Board will not accept requests of a general nature for any files which may be relevant to the reviewable or appealable decision or the issue under review or appeal.

A worker may submit a request for update disclosure where information has been added to the file since the previous disclosure. Where disclosure has been granted to a worker, dependant or employer in situations involving a review or appeal, file updates are automatically provided up to the time the review or appeal is heard. The file may be inspected if it is so desired.

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

### **#99.32**      *Provision of Copies of File Documents*

A copy of all the documents on the claim file will be sent out automatically on receipt of a request for disclosure from a worker or an authorized representative.

Where an employer has a right to receive disclosure of a claim file, that disclosure will consist of the same disclosure which would be granted to the worker.

Only one copy of each claim file is provided. The person entitled to disclosure must decide whether the copy is to go to them or to an authorized or a designated advocate or representative or, if there is more than one, which of them should receive the copy.

File copies may be mailed out or picked up at a Board office.

Effective May 1, 1993, no fees are charged workers for the copy of their claim files. Fees are also not charged employers for a copy of claim files where they are entitled to disclosure.

### **#99.33**      *Personal Inspection of Files*

If the recipient of the copies wishes, an appointment may be made to inspect the file in person.

Personal inspection of the file may take place at the Board's Richmond office or at any other Board office outside the Richmond area by prior appointment only. The office used in each case will be the one closest to the requestor's residence, unless another office is specifically named.

Any person attending at a Board office to view a file in person or to pick up copies will normally be required to provide personal identification containing the person's photograph (e.g. driver's licence) and a social insurance card.

Explanations about what is in the file must be sought from the person or body dealing with the matter, a Workers' Adviser, an Employers' Adviser, or the person's own representative.

**EFFECTIVE DATE:**            June 1, 2009 – Delete references to Board officers.  
**APPLICATION:**              Applies on or after June 1, 2009

## #99.34 *Disclosure*

As soon as practicable, after a request for a review has been filed, the Board must provide the parties to the review with a copy of its records respecting the matter under review.

As soon as practicable after the Board has been notified by the Workers' Compensation Appeal Tribunal that an appeal has been filed, the Board must provide the parties to the appeal with a copy of its records respecting the matter under appeal.

If it is not a review or appeal situation, a worker may obtain disclosure from the Board. Where disclosure is available pursuant to the disclosure policies and it is desired simply to inspect the original file in person at an office of the Board, without receiving a copy of the file or after the receipt of a copy, the request may be made directly to the Board office concerned.

Requests for disclosure involving information relating to sexual assault claims where the employer is alleged to be the perpetrator of the assault will be referred to the Sensitive Claims Area (see policy item #99.30).

<b>EFFECTIVE DATE:</b>	June 1, 2009 – Delete references to Client Service Managers of the appropriate Service Delivery Location and outside the Richmond area.
<b>HISTORY:</b>	March 3, 2003 – Addition of provision for disclosure after request for review and after appeal filed to WCAT. Deletion of reference to address where requests for disclosure must be submitted by employers and workers. Applies to all decisions made on or after March 3, 2003.
<b>APPLICATION:</b>	Applies on or after June 1, 2009

## #99.35 *Complaints Regarding File Contents*

Only where it is personal information which is irrelevant to the claim, does the Board permit the deletion or removal from claim files of statements or documents to which a worker, employer or other person referred to on the file objects. A person making an objection as to the accuracy of file information will be allowed to place on the file statements or material to rebut the statements to which there is an objection. However, the Board will not make a ruling on a dispute over the accuracy of file information save when it is necessary in the normal course of events for the purpose of reaching a decision on the merits of the claim or other matter. Where the person making the objection is the worker, anyone who had access to the file in the one-year period prior to the annotation to the record will be informed.

A complaint that a comment on a Board file is pejorative may be forwarded to the President. If it is concluded that the comment is pejorative, the comment will be stamped, or annotated electronically where appropriate, to identify the comment as pejorative and to refer the reader to the correcting documentation.

### **#99.40 Tape Recordings of Interviews**

Where an enquiry interview has been conducted by the Board, a copy of the tape recording of the interview will be supplied upon request to the worker or their authorized or designated representative. If a review has been requested or an appeal has been filed, a copy may also be provided to the employer or their authorized representative.

A person being interviewed, or any other person entitled to be present at an enquiry, may, if desired, record the proceedings.

**EFFECTIVE DATE:** June 1, 2009 – Delete reference to officer.  
**HISTORY:** March 3, 2003 – Insert reference to review.  
**APPLICATION:** Applies on or after June 1, 2009

### **#99.50 Disclosure to Public or Private Agencies**

Where a public or private agency requests disclosure of all or part of a claim file, the Board will only comply with the request in keeping with the provisions of the *Freedom of Information and Protection of Privacy Act* (FIPPA). The following are the more common examples where disclosure will be provided in response to such a request:

- (a) Where an appropriate signed consent has been received from the worker.
- (b) To any agency having statutory authority allowing access to personal information.
- (c) To comply with a subpoena, warrant or order issued or made by a court, person or body with jurisdiction to compel the production of the information.
- (d) To a member of the Legislative Assembly who has been requested by the worker to assist in resolving a problem.
- (e) If the Board determines that compelling circumstances exist which affect the health or safety of an individual.

### **#99.51**      *Legal Matters*

If a staff member is directly served with a subpoena, the Board's General Counsel or delegate must be advised immediately. If a request is received from a lawyer for information from a claim file, the request is forwarded to the Legal Disclosure Clerk.

At the request of the Board's General Counsel, a Director or designate will be asked to respond to a subpoena or other request for information from a lawyer.

**EFFECTIVE DATE:**            June 1, 2009 – Delete references to Compensation Services Division, Adjudicator and Board officer.

**APPLICATION:**                Applies on or after June 1, 2009

### **#99.52**      *Other Workers Compensation Boards*

The Board has authorized the exchange of copy documents with other Boards. The Board will also inform other Boards of the amount of any permanent disability award being paid to a worker by this Board.

### **#99.53**      *Government of Canada*

In referring workers to a department of the Government of Canada for assistance in job placement, the Board may, with the worker's signed consent, furnish that department with a brief description of their physical limitations.

### **#99.54**      *Canada Pension Plan*

The Board will take all reasonable steps to assist a disabled worker in obtaining benefits to which she or he may be entitled. The Board will provide the Canada Pension Plan, on request and with the worker's release, a report setting out the facts pertaining to the claim, a report to include the date and nature of the accident, the nature of the injury, a very brief resume of the medical findings and the medical assessment of the remaining permanent disability. The Plan is provided with the names of practicing doctors who had been involved in the case. There is no charge for this information.

Effective September 3, 1996, the F.I.P.P. Office of the Board will handle requests from the Canada Pension Plan for information. Where the Board receives a request authorized by the worker or by statute, the F.I.P.P. Office will provide Canada Pension Plan with copies of documents specified in the request. Any charge for this service is paid by CPP.

**EFFECTIVE DATE:** June 1, 2009 – Delete reference to Medical Services Department and update reference to F.I.P.P. Office.  
**APPLICATION:** Applies on or after June 1, 2009

**#99.55** *Ministry of Housing and Social Development*

If the Ministry of Housing and Social Development has a debt owing to them, the Board will disclose to the Ministry the amount of any compensation being paid by the Board.

**EFFECTIVE DATE:** June 1, 2009 – Update reference to Ministry of Housing and Social Development.  
**APPLICATION:** Applies on or after June 1, 2009

**#99.56** *Police*

Information may be disclosed to police departments for the purpose of contacting a next of kin or for the purposes of a law enforcement proceeding.

**#99.57** *Government Employees Compensation Act*

Where an election form signed by the worker is on file, information contained in third party claims for employees covered under the *Government Employees Compensation Act* may be released to the Government of Canada in order to properly pursue the right of action to which it is subrogated.

**#99.60** **Information to Other Board Departments**

For inspection and prevention purposes, the details of any claims received where there is a potential to prevent further recurrences of the situation are referred to the Prevention Division. Examples of this would be scaffolding collapses, explosions, excavation cave-ins, dangerous work practices, etc. Referral is also made in every case where a worker complains about work safety conditions. Where the Board becomes aware of an excessive number of injuries of the same type or even of a different type with one employer, a notification of this observation is also sent to the Prevention Division.

**EFFECTIVE DATE:** June 1, 2009 – Delete references to Claims Adjudicators and Claims Officers.  
**APPLICATION:** Applies on or after June 1, 2009

## **#99.70 Media Enquiries or Contacts**

Unless designated as a media spokesperson, staff at the Board are to refer all media enquiries or contacts to the Communications Department.

**EFFECTIVE DATE:** June 1, 2009 – Update reference to the Communications Department.

**APPLICATION:** Applies on or after June 1, 2009

## **#99.80 Insurance Companies**

On receipt of a signed consent from the worker or dependant, information from a claim file to which the worker or dependant would have access may be disclosed to an insurance company. The signed consent must be directed specifically to the Board and clearly state the information which may be released. It should also refer to a specific claim or specific claims, and must have been signed within 24 months of its date of receipt. See also policy item #48.20.

## **#99.90 Disclosure for Research or Statistical Purposes**

The Board may disclose personal information for a research purpose, including statistical research, only if:

- (a) the research purpose cannot reasonably be accomplished unless that information is provided in individually identifiable form or the research purpose has been approved by the Information and Privacy Commissioner.
- (b) any record linkage is not harmful to the individuals that information is about and the benefits to be derived from the record linkage are clearly in the public interest.
- (c) the Board has approved conditions relating to the following:
  - (i) security and confidentiality;
  - (ii) the removal or destruction of individual identifiers at the earliest reasonable times;
  - (iii) the prohibition of any subsequent use or disclosure of that information in individually identifiable form without the express authorization of the Board, and

- (d) the person to whom that information is disclosed has signed an agreement to comply with the approved conditions, the provisions of the *Freedom of Information and Protection of Privacy Act* and any of the Board's policies and procedures relating to the confidentiality of personal information.

## **#100.00 REIMBURSEMENT OF EXPENSES**

Set out below are the rules relating to the reimbursement of expenses for people attending at the Board or elsewhere in connection with claims or Review Division inquiries.

The principles relating to expenses incurred in connection with medical examinations and treatment and vocational rehabilitation programs are dealt with in policy item #82.00 and policy item #83.00.

The Board may be ordered by the Workers' Compensation Appeal Tribunal to pay certain expenses. Section 7 of the *Workers Compensation Act Appeal Regulation* (B.C. Reg. 321/2000) provides that the Board may be ordered by the Workers' Compensation Appeal Tribunal to reimburse a party to an appeal under Part 4 of the *Act* for the following kinds of expenses:

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

However, the Workers' Compensation Appeal Tribunal may not order the Board to reimburse a party's expenses where those expenses arise from a person representing the party or the attendance of a representative of the party at a hearing or other proceeding related to the appeal.

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

**APPLICATION:** To adjudicative decisions on or after the effective date.

## **#100.10 Claimants**

In addition to the specific requirements set out below, the worker must satisfy the general requirements in policy item #82.10 and policy item #83.10 for the payment of transportation and subsistence.

### *#100.12 Claims or Review Inquiries*

Where a worker is attending on a claims or review inquiry, the payment of expenses is discretionary. There will be no undertaking to pay expenses and no advance.

1. Where the claims inquiry or review results in a decision for the worker, the discretion will normally be exercised in favour of payment. But payment should be refused if it is concluded that the inquiry or review was brought about unnecessarily by the worker.

For example, payment might be refused on a review where it is concluded that the denial of the claim in the first instance resulted from misleading information supplied by the worker.

2. Where the claims inquiry or review results in a decision against the worker, payment of expenses will normally be refused. But payment may be allowed if there is special reason. An example might be, where, although the claim was unfounded, the bringing of the review resulted from misleading reasons for the decision being given in the first instance.

These provisions apply only where people are notified to come for a formal claims or review inquiry. Expenses are not reimbursed for people coming to the Board to make enquiries, or for ordinary discussions.

**EFFECTIVE DATE:** March 3, 2003 (as to references to review)

**APPLICATION:** Not applicable.

### *#100.13 Medical Review Panels*

On an appeal to a Medical Review Panel under section 58(3) or (4) or a referral to a Medical Review Panel by the Board under section 58(5), expenses will be paid regardless of the result, unless it is concluded that the worker was misleading the Board or the doctor who completed the certificate initiating the appeal. Travel warrants may be issued, and accommodation may be offered if required. Policy item #100.15 applies where the worker resides outside the province.

### *#100.14 Amount of Expenses*

The amount of expenses paid is calculated in accordance with the rules set out in policy item #82.20 (transportation), policy item #83.20 (meals and accommodation) and policy item #83.13 (lost time from work where the worker is not already in receipt of temporary disability or vocational rehabilitation benefits from the Board).

### *#100.15 Worker Resides Outside the Province*

The general principle stated in policy item #82.10 is that, where the Board is paying travel costs of a worker located outside the province, it will only pay the portion attributable to travel in this province. This also applies to claims and review inquiries but there are some exceptions to this principle which apply here.

Where a worker resides outside the province and is specifically requested by the Board to attend a claims inquiry or a review by the Review Division, the full cost of the trip will be paid by the Board.

**EFFECTIVE DATE:** June 1, 2009 – Delete references to Medical Review Panel.  
**HISTORY:** March 3, 2003 – Insert references to review.  
**APPLICATION:** Applies on or after June 1, 2009

### **#100.20 Employers**

The expenses of an employer's representative may be reimbursed on the same basis as for a worker, except that compensation benefits for lost time from work are not payable.

Not more than one employer's representative will be eligible for reimbursement for attendance at a claims inquiry or a review by the Review Division unless the second or other representative is needed as an additional witness.

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

### **#100.30 Witnesses and Interpreters**

The expenses of a witness or interpreter will be paid when they have been subpoenaed or have been requested to attend by the Board.

In other cases, the expenses of an independent witness will be paid where, following the claims inquiry or review by the Review Division, it appears that it was reasonable for the worker or employer as the case may be to have assumed, prior to the claims inquiry or review by the Review Division, that the attendance of the witness would be necessary. (If a worker or employer intends to bring more than two witnesses, or intends to bring any witness from a distance of more than twenty-five miles, they should check first by telephone with the Board.)

Where the expenses of a witness are payable, the amount will be the same as for a worker. Income-loss benefits under policy item #83.13 will be paid for lost time from work. The applicable maximum and minimum will be those in effect at the time the lost time is incurred.

**EFFECTIVE DATE:** June 1, 2009 – Delete reference to officer or review officer.  
**HISTORY:** March 3, 2003 – Insert reference to the Review Division.  
**APPLICATION:** Applies on or after June 1, 2009

#### **#100.40 Fees and Expenses of Lawyers and Other Advocates**

No expenses are payable to or for any advocate. Nor does the Board pay fees for legal advice or advocacy in connection with a claim for compensation. (36) The Board will not pay the legal costs of a worker or employer in connection with court proceedings to challenge a Board decision beyond what it may become subject to pay following the court's decision under the general law of costs.

#### **#100.50 Expenses Incurred in Producing Evidence**

Where a worker incurs expense in producing evidence of a kind which the Board would have sought had it not been produced by the worker, these expenses will be reimbursed by the Board as an item of administrative cost. In this connection, it makes no difference whether the expense was incurred directly or through a lawyer or other representative. However, confusion should not be made between the expenses incurred by the lawyer or other representative on behalf of the worker and the fees of the lawyer or representative for work done. Only the former are reimbursable.

The cost of medical reports obtained by a worker or employer will also be paid by the Board where, following the claims inquiry or review by the Review Division, it appears reasonable for them or their representative to have assumed, prior to the claims inquiry or review by the Review Division, that the provision of the report was necessary. These costs may be paid even if, after the matter is

concluded, it is determined that they had not specifically served to assist in the enquiry.

The Board, in a decision on a claim, refused to pay for medical reports obtained by a worker's lawyer. Although it was a normal and prudent action on the part of a responsible lawyer to seek information in order to acquaint himself properly with his client's problem before pursuing it before the Board, the information contained in the reports could have been obtained from the worker's attending physician at no cost. A simple request to the attending physician, together with a release from the worker, would have been sufficient.

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

**EFFECTIVE DATE:** June 1, 2009 – Delete reference to officer.  
**HISTORY:** March 3, 2003 – Insert references to the Review Division.  
**APPLICATION:** Applies on or after June 1, 2009

### **#100.60 Decision on Expenses**

With regard to claims inquiries, any necessary decisions relating to expenses would be made by the Board. With regard to reviews or appeals, decisions relating to expenses are made by the Review Division or the Workers' Compensation Appeal Tribunal, respectively.

**EFFECTIVE DATE:** June 1, 2009 – Delete reference to officer.  
**HISTORY:** March 3, 2003 – Insert references to the Review Division and the Workers' Compensation Appeal Tribunal.  
**APPLICATION:** Applies on or after June 1, 2009

### **#100.70 The Awarding of Costs**

The provisions in policy item #100.00 to policy item #100.60 relate to the payment of expenses by the Board. An order for the payment of costs by one party to another under section 100 of the *Act* is a separate matter, and is an alternative that may be considered in an appropriate case.

Section 100 provides that “The Board may award a sum it considers reasonable to the successful party to a contested claim for compensation or to any other contested matter to meet the expenses the party has been put to by reason of or incidental to the contest, and an order of the Board for the payment by an employer or by a worker of a sum so awarded, when filed in the manner provided for the filing of certificates by section 45(2), becomes a judgment of the court in which it is filed and may be enforced accordingly.”

A “contested claim”, for the purposes of section 100, is one in respect of which there has been a review by the Review Division by the worker or the employer.

An award under section 100 might be made on a review but only in unusual cases. The section is limited to cases where the worker or employer abuses their respective rights under the *Act*. For instance, the worker or employer may put the opposite party to the expense of an appeal for no good reason. In other words, it may appear that a review was pursued simply because the right to request a review existed and without any substantial grounds on which the position could be argued.

An award will not likely be made under section 100 in favour of a successful appellant. The section requires that the expenses in respect of which the award is made be “. by reason of or incidental to the contest, . . .” Since the appeal will be proceeded with and resolved whether or not it is opposed by the other party, it cannot normally be said that the expenses of the appellant are due to the other party’s “contest” of the review. Where the review is not opposed by the other party, the reasons for not making an award become even stronger.

Section 6 of the *Workers Compensation Act Appeal Regulation* (B.C. Reg. 321/2002) provides that the Workers’ Compensation Appeal Tribunal may award costs related to an appeal under Part 4 of the *Act* to a party if the Workers’ Compensation Appeal Tribunal determines that:

- another party caused costs to be incurred without reasonable cause, or caused costs to be wasted through delay, neglect or some other fault;
- the conduct of another party has been vexatious, frivolous or abusive; or
- there are exceptional circumstances that make it unjust to deprive the successful party of costs.

**EFFECTIVE DATE:** June 1, 2009 – Delete reference to Medical Review Panel.

**HISTORY:** March 3, 2003 – Insert references to review and section 6 of the *Workers Compensation Act Appeal Regulation*.

**APPLICATION:** Applies on or after June 1, 2009

### #100.71 *Application for Costs by Dependant*

On an application under former section 11 of the *Act*, the Board certified that the defendant to a third party action was not an employer under the *Act*. The plaintiff then applied for an order for costs of the proceedings before the Board to be paid by the third party defendant. The Board determined that:

“ . . . the authority of the Board to enforce payment of an order for costs is limited to an order for payment by an employer, or by a worker. The Third Party in this case is neither an employer nor a worker under Part I, and the Board has therefore no authority to make an order for costs against the Third Party. It may well be that this limitation under section 100 has a historical explanation that does not reflect any rational policy currently relevant. But it is a clear limitation in the *Act*, and it must therefore be followed.”

The question arises whether an award under section 100 can be made in favour of the dependants of a deceased worker. Such an award would not contradict the previous determination, as the person against whom it would be made is an employer under the *Act*. However, it was considered unfair to make such an award if the employer could not get a like award against the dependant. Therefore, an award of costs will not be made in favour of a dependant of a deceased worker against an employer.

**EFFECTIVE DATE:** March 3, 2003 (as to reference to former section 11)  
**APPLICATION:** Not applicable.

### #100.72 *What Costs May Be Awarded?*

It would not be reasonable to make an order for costs against a worker or employer in respect of an expense which the Board would not allow under the rules set out in policy item #100.00 to policy item #100.50. Therefore, an award of costs will not include the fees of lawyers and other persons paid to them for advice or advocacy in connection with a claim for compensation.

### #100.73 *Decisions on Applications for Costs*

Only in rare cases will a review by the Review Division be sufficiently without merit to justify an award under section 100.

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

## **#100.75**     *Implementation of Review or Appeal Decision Directing Reassessment or Redetermination*

It may happen that, instead of reaching a specific finding on a matter, the Review Division or the Workers' Compensation Appeal Tribunal will direct that the Board reassess or redetermine something, for example, a permanent partial disability award. The Review Division or the Workers' Compensation Appeal Tribunal finding is properly implemented if the reassessment or redetermination is carried out even if the conclusion reached is the same as the one that was previously reviewed by the Review Division or appealed to the Workers' Compensation Appeal Tribunal. However, if the Board officer implementing the Review Division or the Workers' Compensation Appeal Tribunal finding is the same one who made the original decision against which the review or appeal was made, and if that person's decision is still negative, the matter is to be referred to a different Board officer for a second look. If a difference of opinion results from the second look, the decision of the second Board officer will prevail.

Where, in addition to directing the reassessment or redetermination, the Review Division or the Workers' Compensation Appeal Tribunal makes some specific findings of fact, for example, that the worker was unable to carry out certain jobs, the Board is bound by those findings.

Where the reassessment or redetermination results in no change in the original Board decision, a review or an appeal lies back to the Review Division or the Workers' Compensation Appeal Tribunal, respectively.

<b>EFFECTIVE DATE:</b>	June 1, 2009 – Delete references to Compensation Services Division.
<b>HISTORY:</b>	March 3, 2003 – This policy item was moved from Chapter 13 and amended to include references to the Review Division or the Workers' Compensation Appeal Tribunal.
<b>APPLICATION:</b>	Applies on or after June 1, 2009

## **#100.80**     **Payment Of Claims Pending Appeals**

### *#100.81 Appeals to the Review Division – New Claims*

The general practice is that no payment is made on a new claim until there has been an adjudication that the claim is valid.

When a decision is made to allow a claim that has been protested by an employer, the employer will be advised of the decision and reasons, where possible by telephone, and given an opportunity to provide any additional

information. This is similar to the requirement in policy item #99.10 that a worker be advised if the indication on a claim is that it may be disallowed. If the decision remains that the claim should be allowed, payments will be commenced immediately and a letter explaining the decision and reasons will be sent to the employer. The letter will advise the employer of their right to request a review by the Review Division.

An employer can request a review up to 90 days from the decision allowing a claim.

If the Review Division reverses the decision to allow the claim, payments are immediately terminated but no attempt is made to recover payment incorrectly made to the worker, unless there was evidence of fraud or misrepresentation. The employer's sector or rate group will be relieved of the claim costs pursuant to policy item #113.10.

**EFFECTIVE DATE:** June 1, 2009 – Delete reference to Claims Department.  
**HISTORY:** March 3, 2003 – This policy item was moved from Chapter 13 and amended to include references to the Review Division.  
**APPLICATION:** Applies on or after June 1, 2009

### *#100.82 Appeals to the Workers' Compensation Appeal Tribunal – Reopening of Old Claims*

If a decision is made to reopen an old claim, the employer is advised in writing. If the employer objects to this decision, the employer will be advised of the right to appeal to the Workers' Compensation Appeal Tribunal.

If the Workers' Compensation Appeal Tribunal reverses the decision to reopen the claim, payments are immediately terminated. No attempt is made to recover payments incorrectly made to the worker unless there was evidence of fraud or misrepresentation. The employer's sector or rate group will be relieved of the claim costs pursuant to policy item #113.10.

**EFFECTIVE DATE:** June 1, 2009 – Delete reference to Claims Department.  
**HISTORY:** March 3, 2003 – This policy item was moved from Chapter 13 and amended to include references to the Workers' Compensation Appeal Tribunal.  
**APPLICATION:** Applies on or after June 1, 2009

## #100.83 *Implementation of Review Division Decisions*

Section 258 of the *Act* provides as follows:

- (1) If, following a review under section 96.2, a review officer's decision requires payments to be made to a worker or a deceased worker's dependants, the Board must
  - (a) begin any periodic payments, and
  - (b) pay any lump sum due under section 17(13).
- (2) In the absence of fraud or misrepresentation, an amount paid under subsection (1) to a worker or a deceased worker's dependants is not recoverable.
- (3) If a review officer has made a decision described under subsection (1), the Board must defer the payment of any compensation applicable to the time period before that decision
  - (a) for a period of 40 days following the review officer's decision, and
  - (b) if the review officer's decision is appealed under section 239, for a further period until the appeal tribunal has made a final decision or the appeal has been withdrawn, as the case may be.
- (4) Subsection (3) applies despite sections 19.1, 22(1), 23(1) or (3), 29(1) or 30(1).
- (5) If the appeal tribunal's decision on an appeal requires the payment of compensation, all or part of which was deferred under subsection (3), interest must be paid on the deferred amount of that compensation as specified in subsection (6).
- (6) Interest payable under subsection (5) must be calculated in accordance with the policies of the board of directors and begins
  - (a) 41 days after the review officer made his or her decision, or
  - (b) on an earlier day determined in accordance with the policies of the board of directors.

The procedures for implementing all Review Division decisions are as follows:

1. Any benefits payable from the date of the Review Division decision forward will be paid without delay.
2. Any benefits payable for the period of time prior to the date of the Review Division decision (retroactive benefits) will be paid after 40 days have elapsed following the date of the Review Division decision unless an appeal has been filed with the Workers' Compensation Appeal Tribunal.
3. If there is an appeal of the decision under section 239 retroactive benefits will not be paid until the Workers' Compensation Appeal Tribunal has made a final decision or the appeal has been withdrawn.
4. The decision of the Workers' Compensation Appeal Tribunal will be implemented upon its receipt by the Board. The worker's entitlement to retroactive benefits which were deferred according to #3 above will then be determined in accordance with the decision of the Workers' Compensation Appeal Tribunal.
5. Where retroactive benefits are payable, after the decision of the Workers' Compensation Appeal Tribunal, interest is to be paid in accordance with the Board's general policy on the payment of interest on retroactive benefits as set out in policy item #50.00. However, where no interest is payable under policy item #50.00 because it is determined that the retroactive benefit was not necessitated by a blatant Board error, interest will be paid beginning 41 days after the date on which the Review Division made its decision. The amount of interest to be paid is to be calculated in accordance with the interest rates set out in policy item #50.00.

**EFFECTIVE DATE:** June 1, 2009 – Delete reference to officer.

**HISTORY:** March 3, 2003 – This policy was moved from Chapter 13 and amended to include references to section 258 of the *Act*, the Review Division and the Workers' Compensation Appeal Tribunal and delete a reference to former policy item #45.61.

**APPLICATION:** Applies on or after June 1, 2009

## NOTES

- (1) S.53(2)
- (2) S.53(3)
- (3) See policy item #94.11, *Form of Report*
- (4) *Workers' Compensation Board of British Columbia, W.C.B. News*, November – December, 1975, 4
- (5) S.55(1)
- (6) S.55(1)
- (7) S.12; See policy item #49.00, *Incapacity of a Worker*
- (8) S.54(2)
- (9) S.54(3)
- (10) S.54(6)(b)
- (11) S.54(9)
- (12) See policy item #34.40, *Pay Employer Claims*
- (13) See policy item #74.10, *General Position of Physicians and Qualified Practitioners*
- (14) S.56(1)(b)
- (15) S.56(1)(c)
- (16) S.56(5)
- (17) S.56(1)(d)
- ~~(18)~~ ~~S.99~~ **DELETED**
- (19) See Chapter 16, *Third Party/Out-of-Province Claims*
- (20) See policy item #112.30, *Workers Also Entitled to Compensation in Place of Injury*; policy item #113.30, *Interjurisdictional Agreements*
- (21) See policy item #73.54, *Worker Voluntarily Leaves the Province*
- (22) See policy item #34.40, *Pay Employer Claims*
- (23) *Workers' Compensation Board of British Columbia, W.C.B. News Bulletin*, September – October, 1973
- (24) S.5(4); See Item C3-14.20, *Accident – Section 5(4) Presumption*
- (25) S.6(3); See policy item #26.21, *Schedule B Presumption*
- (26) S.6(11); See policy item #29.50, *Presumption Where Death Results from Ailment or Impairment of Lungs or Heart*
- (27) See policy item #95.10, *Form of Reports*

- (28) See policy item #97.10, *Evidence Evenly Weighted*
- (29) See policy item #74.60, *Concurrent Treatment*
- (30) S.88(2)
- (31) S.88(4)
- (32) S.88(5)
- (33) S.21, *Evidence Act*
- (34) ~~S.95(2)~~ **DELETED**
- (35) ~~See policy item #103.00~~ **DELETED**
- (36) See policy item #48.10, *Solicitors' Liens*

