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Update 2005 - 1

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

This update of the *Rehabilitation Services & Claims Manual* contains amendments to the *Manual* implemented since update 2004 - 7.

This amendment includes:

- Policy item #34.11, *Selective/Light Employment*
- Policy item #99.10, *Disclosure of Issues Prior to Adjudication*
- Policy item #99.20, *Notification of Decisions*
- Policy item #99.22, *Procedure for Handling Complaints or Inquiries About a Decision*
- Chapter 14, *Changing Previous Decisions*

A summary of the amendments is attached and the amended pages are included as part of the package effective January 1, 2005.

If you have any questions regarding subscription information for updates to the *Rehabilitation Services & Claims Manual*, please call WCB Customer Service at the following numbers:

Local phone: 604-232-9704
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Margaret Eckenfelder
Vice President
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Attachments

Rehabilitation Services & Claims Manual, Volume II
SUMMARY OF AMENDMENTS – Update 2005 – 1

Table of Contents	Pages vii – viii	Updated
Chapter 5	Pages 1 – 8	<p>Policy item #34.11</p> <p>Revisions to this policy include:</p> <ul style="list-style-type: none"> • adding a definition of selective/light employment; • confirming the Board officer’s responsibility for determining whether the selective/light offer is safe for the worker from a review of the medical evidence; and • adding a date of when to adjust benefits when a Board officer has determined that an employer’s selective/light offer is suitable and the worker unreasonably refused to return to work.
Chapter 12	Pages 51 – 54	<p>Policy items #99.10, #99.20, and #99.22</p> <p>Housekeeping changes to:</p> <ul style="list-style-type: none"> • remove the reference to the non-existent list of designated advocates; and to clarify that written authorization is required for disclosure of information to any advocate or representative. • Further amendment made to policy item #99.20 to clarify that employers are only entitled to disclosure of personal information on a need to know basis, as required for the adjudication and administration of the claim.
Chapter 14	Pages 1 – 5	<p>C14-101.01</p> <p>To clarify what constitutes a new matter for adjudication and the implementation of Review Division and Workers’ Compensation Appeal Tribunal decisions.</p> <hr/> <p>C14-102.01</p> <p>To clarify recurrence of an injury and reopening on application versus on own initiative.</p> <hr/> <p>C14-103.01</p> <p>To provide that the correction of an administrative error such as a mathematical or clerical error does not constitute a reconsideration.</p>

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CHAPTER 5

WAGE-LOSS BENEFITS

#33.00 INTRODUCTION

Wage-loss benefits are payable where an injury or disease resulting from a person's employment causes a period of temporary disability from work. These benefits usually commence shortly after the initial acceptance of a claim and may be total (section 29) or partial (section 30). They cease when the worker recovers from the injury or the condition becomes a permanent one. In the latter event, the worker is entitled to be assessed for a permanent partial disability award. This entitlement is dealt with in Chapter 6.

Wage-loss benefits are calculated on the basis of a worker's "average net earnings". The computation of average net earnings is dealt with in Chapter 9.

#34.00 TEMPORARY TOTAL DISABILITY PAYMENTS

Where a temporary total disability results from an injury, section 29(1) provides that the compensation consists of periodic payments to the injured worker equal in amount to 90% of her or his average net earnings.

#34.10 Meaning of Temporary Total

It is obvious that for every claim there must be physical impairment as the result of a work-related injury or occupational disease. It is the instigating factor without which the system never comes into play. Once it is found that a worker has suffered such an impairment it becomes necessary to determine the extent of compensation payable, i.e. the consequences of the impairment. There are, therefore, two considerations on every claim. Firstly, the impairment itself, and secondly, the entitlement to benefits arising from the impairment.

The words "temporary", "permanent", "partial", and "total" found in sections 22, 23, 29 and 30 are applicable only to the impairment component of the claim and are not to be related to its compensable effects. To differentiate between the "temporary" and "permanent" consequences of an impairment is possible only by reference to the impairment itself. Once it has been determined that a worker has a temporary or permanent, partial or total medical impairment, benefits to compensate for the consequences of that impairment shall be paid in accordance with the requirements of the appropriate section of the *Act*.

It follows from the above that in order to be eligible for benefits under section 29(1) a worker must have a temporary total physical impairment as a result of the injury.

A “temporary” physical impairment is one which is likely to improve or become worse and is therefore not stable. Realistically speaking, ongoing change is a natural feature of human physiology. Impairments resulting from an injury commonly deteriorate or improve over a period of years. However, an impairment is not considered temporary simply because it is possible that, as the worker becomes older, the condition may change or the worker may have to undergo further treatment. It only remains temporary when such a change can reasonably be foreseen in the immediate future. (1)

Most compensable injuries and diseases involve an initial period of temporary disability during which wage-loss benefits are paid. This disability will usually improve in time until it disappears entirely or becomes permanent. However, in the case of some diseases there is no initial period of temporary disability; the condition is permanent right from the beginning and no wage loss is payable.

Raynaud’s Phenomenon, is one of these diseases. There are also others, for example, hearing loss caused by exposure to industrial noise. The worker’s only entitlement in these cases is to be assessed for a permanent partial disability award.

Even if a worker is found to have a temporary total physical impairment, no wage-loss payments will be made unless that impairment in fact causes the cessation of regular employment. If the impairment causes only a partial cessation from this work or some alternative light work is taken up, benefits are calculated under section 30.

References to “physical impairment” in the above paragraphs include “psychological impairment” where the worker’s disability is psychological in nature.

#34.11 Selective/Light Employment

STATEMENT OF PRINCIPLE

Selective/light employment is a temporary work alternative, offered by an employer, that is intended to promote a worker’s gradual restoration to the pre-injury level of employment. The arrangement may involve duties different from the pre-injury employment, or some modification of the pre-injury duties and/or hours of work. Selective/light employment arrangements may involve consultation with the worker, employer, the worker’s attending physician or other medical practitioners and the union.

Selective/light employment is typically offered at or soon after the date of injury, generally prior to the Board’s involvement on the claim. Selective/light employment differs from graduated return to work programs which are normally initiated after the worker has participated in some form of medical treatment or rehabilitation program.

The Board supports selective/light employment as an important component of a worker's rehabilitation and recognizes the value of maintaining an injured worker's positive connection to the workplace. It has been amply demonstrated that the earlier a worker is able to safely return to productive employment following an injury, the more likely he or she is of obtaining maximum recovery.

CRITERIA

To ensure that the early return-to-work is appropriate, all selective/light employment arrangements must meet the following conditions:

- While the compensable injury may temporarily disable the worker from performing his or her normal work, the worker must be capable of undertaking some form of suitable employment.
- The work must be safe, that is, it will neither harm the worker nor slow recovery. The work must be within the worker's medical restrictions, physical limitations and abilities. Where there is a disagreement regarding the safety of the selective/light offer and the WCB is required to intervene, the Board officer is responsible for determining the safety of the work after considering medical opinions, such as opinions from the attending physician and the Board Medical Advisor, and other relevant information.
- The work must be productive. Token or demeaning tasks are considered detrimental to the worker's rehabilitation.
- Within reasonable limits, the worker must agree to the arrangement.

INTERVENTION

The Board recognizes that the successful development of selective/light employment opportunities depends on the cooperation of all parties in the workplace. In the following situations, the Board will intervene to determine if a particular offer of selective/light employment is suitable:

- The worker and/or the worker's attending physician disagree with the employer's position that the work is safe.
- The worker and employer are in disagreement over the terms of the return-to-work.
- There is a request for intervention by either the worker or employer.
- The Board officer adjudicating the claim considers that further inquiry is required.

ADJUDICATION

On intervention, the Board's evaluation will be based on, but not limited to, a detailed description of the employment being offered, including the physical requirements and detailed medical information outlining the worker's medical restrictions, physical limitations and abilities.

Where a worker refuses to accept the offer, the Board will consider the reasons for refusal and determine if they are reasonable. In making this determination, a Board officer will give regard to the requirements of the work, medical opinion(s) and other evidence regarding the worker's medical restrictions, physical limitations and abilities. Notwithstanding, Board officers have discretion to consider additional factors or evidence relevant to the case, such as transportation (see policy item #82.00) and child-care (see policy item #84A.00).

Should the Board determine that the worker's refusal is unreasonable, benefit entitlement is determined under section 30 of the *Act*. For example, the worker does not provide the selective/light duties to the attending physician or the worker refuses to return to work after the physician has determined the duties are suitable. Benefit entitlement will be adjusted effective the date the selective/light employment was suitable and available, as determined by the Board officer.

Where a worker accepts suitable selective/light employment, benefit entitlement will be determined under section 30 of the *Act*. Benefit entitlement will be adjusted effective the date the selective/light employment was suitable and available, as determined by the Board officer.

EFFECTIVE DATE: January 1, 2005
APPLICATION: Applies to all injuries occurring on or after
January 1, 2005

#34.12 Worker in Receipt of Permanent Disability Award

Wage-loss benefits are terminated when the worker's condition becomes permanent and prior to the assessment of any permanent disability award. However, they may again become payable because a further work injury or a natural relapse in the condition for which the permanent disability award is being paid causes a further period of temporary disability.

With regard to the latter situation, it is recognized that no condition is ever absolutely stable or permanent; there will commonly be some degree of fluctuation. Nevertheless, a permanent disability award will be granted when, though there may be some changes, the condition will, in the reasonably foreseeable future, remain essentially the same. The fluctuations in the condition of a worker receiving a permanent disability award may be such as to require the

worker to stay off work from time to time. The question then arises whether wage-loss benefits should be paid for these periods. If the fluctuations causing the disability are within the range normally to be expected from the condition for which the worker has been granted a permanent disability award, no wage loss is payable. The permanent disability award is intended to cover such fluctuations. Wage loss is only payable in cases where there is medical evidence of a significant deterioration in the worker's condition which not only goes beyond what is normally to be expected, but is also a change of a temporary nature. If the change is a permanent one, the worker's permanent disability award will simply be reassessed.

#34.20 Minimum Amount of Compensation

Wage-loss compensation cannot be less per week than the minimum set out below, unless the worker's average earnings are less than that sum per week, in which case compensation is paid in an amount equal to average earnings. (2)

			\$ Per Week
January 1, 2004	—	December 31, 2004	318.95
January 1, 2005	—	December 31, 2005	326.25

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

The minimum is subject to cost of living adjustments as described in policy item #51.20. However, these adjustments only apply to injuries or disablements occurring after they come into force. Existing payments are not automatically increased to a new minimum, although they may be the subject of cost of living adjustments in their own right.

#34.30 Commencement of Payment

Section 5(2) provides that "Where an injury disables a worker from earning full wages at the work at which the worker was employed, compensation is payable. . . from the first working day following the day of the injury; but a health care benefit only is payable . . . in respect of the day of the injury."

While the plain wording of the section would seem clearly to indicate that "day of the injury" means calendar day, the Board finds that the intention of the legislation is not to provide payment for the "shift" on which the worker is injured but to provide payment for any subsequent "shift" on which the worker is disabled. Payment of compensation, therefore, will commence effective the shift next following the shift on which the worker is injured.

#34.31 *Worker Continues to Work After Injury*

If a worker continues to work beyond the day of the injury, no compensation is payable until it actually causes a lay-off from work. If the worker works or is paid for part of the day on which the lay-off occurs, the amount of compensation paid for that day is as follows:

- (a) if he or she works or is paid for one quarter of the day or less, compensation is paid for the full day;
- (b) if he or she works or is paid for more than one quarter but less than three quarters of the day, compensation is paid for half the day;
- (c) if he or she works or is paid for three quarters of the day or more, compensation is not paid for the day.

Except where section 34(1) is being applied, (3) the employer is not refunded any money paid to the worker for time not worked on the day when he or she lays off work.

The above rules apply equally where the worker becomes disabled from working following a recurrence of a compensable condition.

#34.32 *Strike or Other Lay-Off on Day Following Injury*

In cases where a worker's job would not have been available during a period of disability, or for some reason the worker cannot or will not be returning to the prior job upon recovery, the following general guidelines will apply.

1. Where the injury disables the worker beyond the day of the injury and this results in an actual loss of earnings or a potential loss of earnings, the requirement of section 5(2) will be met and wage-loss compensation will be paid.
2. Where the disability beyond the day of injury does not result in any actual or potential loss of earnings, the requirements of section 5(2) will be deemed to have not been met.

In interpreting "potential loss" no rigid rules can be established since every case will have to be determined on the information received. In situations where there is a lay-off due to lack of work, a worker would normally be considered as having suffered a potential loss. The position would be similar where a partially disabled worker has continued work on light work and has been laid off due to a lack of work, but payments on such a claim would be considered under section 30 of the Act. The general expectation in those situations is that the worker would, if not injured, have immediately sought new employment and the Board should not speculate as to if and when it would have been found. If, however, there is

evidence to rebut this general expectation, the Board may conclude in a particular situation that there was no actual or potential loss. For example, suppose a homemaker has been injured in the course of a single day's work at a polling station during an election and has no other attachment to the labour force whatsoever. The homemaker would not normally be available on the general labour market beyond the one day of work at the polling station.

There are other situations where, immediately following the lay-off, it would not normally be expected that the worker would seek other work, for example, strikes, a statutory holiday, weekends or normal days off, vacations or absences required for medical treatment unrelated to the work injury. It will normally be considered that there is no loss or potential loss in such cases. Again, however, the opposite conclusion may be reached if there is evidence that the worker would have undertaken other work but the injury prevented it.

It should be made clear that the above rules only apply at the point of the original lay-off. Once the Board has commenced the payment of temporary disability benefits, it does not normally discontinue them simply because, irrespective of the injury, the worker would not have been working for some period of time. This applies even in cases where the worker recovers from the initial disability and benefits are terminated but the worker subsequently suffers a recurrence within three years of the compensable condition. The fact that the worker is, for example, on strike at the time of the recurrence does not bar the payment of benefits for temporary total disability.

See policy item #35.30 for policy on the duration of temporary disability benefits.

#34.40 Pay Employer Claims

Section 34(1) provides that "In fixing the amount of a periodic payment of compensation, consideration must be had to payments, allowances or benefits which the worker may receive from the worker's employer during the period of the disability, including a pension, gratuity or other allowance provided wholly at the expense of the employer, and a sum deducted under this section from the compensation otherwise payable may be paid to the employer . . ."

The section does not provide that any payment made by the employer shall be deducted from the compensation, or that any compensation deducted shall be paid to the employer. It requires that the Board must consider the matter, and that any compensation deducted under this section may be paid to the employer. The section is permissive, not mandatory, and the question is, therefore, in what circumstances a deduction should be made.

In practice, employers who continue paying full wages to disabled workers are reimbursed in amounts equal to the compensation that would normally be paid to their employees. No refund is made for the difference between the amount of compensation and the worker's regular salary. If an employer continues to pay

25% of a worker's salary or less, full wage-loss payments are made to the worker and no refund made to the employer.

Refunds are made to all employers except for the Federal Government. However, in any case where the Federal Government is not continuing to pay full salary, the Board must pay the wage-loss benefits to the worker.

If a claim is reopened and the worker is carried on full salary by a different employer from the employer at the time of the original injury, the new employer is reimbursed to the same extent as the original employer would have been. This applies even though the original or new employer is an agency or department of the Federal Government.

If an employer has any outstanding liability to the Board for assessments the amount of the liability is deducted from any payments made to the employer.

#34.41 Vacation Pay

If a vacation period or statutory holiday occurs while a worker is receiving wage-loss benefits, the Board continues to pay those benefits or, in the case of a pay employer claim, to the employer.

#34.42 Termination Pay

The language of section 34(1) is broad enough to cover termination pay.

In a Board decision, the worker suffered a compensable injury on October 28. On October 30, the employer terminated the service of the worker, and pursuant to section 19 of the *Mines Act*, the worker received a termination payment roughly equivalent to wages for one month. The Board rejected an application that the compensation payments attributable to the month of November should be paid to the employer under section 34(1).

This was not a voluntary payment by the employer. It was termination pay required by law. If the worker had been fit to do so, he would have been free in early November to take any other job that he could find, receive full wages in respect of that job and still be entitled to the termination pay. In other words, by the law of the Province, he was entitled to be paid twice over the month of November. Given his disability, he could not do that. But upon being fit again to return to work, he is in the position of one who must find new employment. Termination pay is intended to allow for his being in that position.

This relates only to termination pay under the *Mines Act*. Other arguments may be relevant with regard to other kinds of termination payments. However where the payment is of a similar type or category in that it results from a legislative requirement or a contractual agreement, it will likely be treated in the same manner as that described above.

#99.10 Disclosure of Issues Prior to Adjudication

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

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

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 Adjudicator should, before making the decision, phone the employer to ensure that the employer is aware of the issues relevant to the protest and has an opportunity to comment.

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

#99.20 Notification of Decisions

Where a claim is allowed and there has been no protest from the employer, no reasons are given. The Board simply sends the cheque. Notification of such action will only be disclosed to advocates and representatives where proper written authorization is in place.

When a decision is made to allow a claim that has been protested by an employer, the employer will be notified of the decision and reasons, where possible by telephone. Only personal information which is relevant to the claim

and the issues involved, and that the employer has a need to know, will be disclosed. A letter explaining the decision and reasons will be sent in any case where the employer cannot be contacted by telephone, or where in the course of the telephone conversation the employer indicates that in spite of the explanation there is a dissatisfaction with the decision. The letter is sent to the employer, with a copy to the worker. The guidelines outlined in the following paragraph, with regard to letters sent to workers, should be followed to the extent that they apply. Employer advocates are notified in the same manner as workers' representatives.

Where a decision is made adverse to a worker, the reasons are stated in a letter to the worker. The guidelines set out below apply in writing these letters. The Board officer will, where appropriate:

1. Specify clearly the matter being adjudicated.
2. Describe investigations carried out, including interviews conducted.
3. Outline the evidence considered.
4. Explain how the evidence was evaluated (specify its reliability; analyze conflicting evidence; give reasons for the weight apportioned to the evidence).
5. Review contact with the worker where the relevant issues were discussed and detail the worker's response.
6. List the various conclusions possible from the evidence.
7. In support of the conclusion reached, explain:
 - a) what evidence was considered favourable, with reasons, and
 - b) what evidence was considered unfavourable, or discounted, with reasons.
8. Point out statutory, policy or discretionary factors involved.
9. Discuss the question of evenly weighted evidence.
10. Summarize the formal decision.
11. Explain what the decision entails regarding non-payment of wage loss compensation, medical accounts, other benefits, etc.
12. Include an explanation of the relevant rights of review and/or appeal.

Notice of the decision will be sent to the employer and to any advocate or representative designated by the worker or employer by written authorization.

Before a review or appeal is initiated, the type of information from a worker's claim file that can be disclosed to the employer and/or authorized advocates and representatives is limited. Employers are only entitled to disclosure of personal information on a need to know basis, as required for the adjudication and administration of the claim. The same approach applies for notification of decisions to health care providers, such as physicians and pharmacists.

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

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

Where a claim has been reopened, the employer and/or authorized advocates and representatives will be notified of the decision.

EFFECTIVE DATE: March 3, 2003 (as to references to evenly weighted evidence and the rights of review and/or appeal)
HISTORY: January 1, 2005 – Housekeeping amendment to require written authorization for disclosure, and to clarify appropriate disclosure principles.
APPLICATION: To all adjudicative decisions on or after the effective date.

#99.21 Notification of Rights of Review and Appeal

In any case where an adverse decision that is reviewable and/or appealable is made with regard to a worker, the worker will be informed of rights of review and/or appeal. The employer will be informed of rights of review and/or appeal where a claim that he or she protested is accepted, where a request for relief of costs is denied or where a request to limit compensation entitlement is denied. In all other cases where an employer makes it known that he or she disagrees with a decision, information about the review and appeal process will be made available to the employer. If a claim is rejected on the basis that it did not involve an employer covered under the *Act* or there was no personal optional protection in force, notification of the review and/or appeal procedures is not automatically conveyed to the injured person.

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

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

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

#99.22 Procedure for Handling Complaints or Inquiries About a Decision

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

Where the worker 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, which should simply be addressed to the Board officer handling the claim or to her or his manager in the Worker and Employer Services Division.

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

EFFECTIVE DATE: March 3, 2003 (as to reference to C14-103.01 and deletion of references to Review Board)

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

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

#99.23 Unsolicited Information

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

**RE: Changing Previous Decisions –
General**

ITEM: C14-101.01

BACKGROUND

1. Explanatory Notes

The *Act* provides the following mechanisms by which the Board may change its decisions:

- reopenings;
- reconsiderations;
- reviews; and
- setting aside for fraud or misrepresentation.

More information about these mechanisms is presented in the Items C14-102.01 - C14-105.01.

2. The Act

See Items C14-102.01 - C14-105.01.

POLICY

This policy clarifies the types of decisions that do not constitute a reconsideration or a reopening of a previous decision.

(a) New matters not previously decided

The need to adjudicate new matters not previously decided and make decisions on these matters may occur at various points during the adjudication of a claim. The limits in the *Act* on the Board's ability to change previous decisions through a reconsideration or a reopening are not intended to restrict the Board's ability to make new decisions in accordance with the *Act* and policy that do not question previous decisions.

Situations in which the Board may make a new decision on a matter not previously decided may generally include, but are not limited to the following:

- Initial entitlement to temporary or permanent disability benefits;

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- Acceptability of additional medical conditions identified during the adjudication of a claim or acceptability of further injury or disease that arises as a consequence of a work injury;
- Sections of the *Act* which give the Board broad discretion to make decisions regarding entitlement at various times over the course of a claim. In applying these provisions, a Board officer may consider a new matter that arises as a result of new information or a change in circumstances that occurs after a previous decision. Two examples are health care and vocational rehabilitation benefits.
- Health care benefit entitlement – Section 21 of the *Act* enables the WCB to approve health care treatment and services to aid in a worker's recovery from the compensable injury or occupational disease. Consideration for health care benefits may occur at various points during the claim as the nature and severity of the worker's compensable injury or occupational disease changes and/or there is a determination that additional treatments or services will assist in the worker's recovery.

Decisions regarding entitlement to health care benefits made as new matters arise, such as a change in the worker's medical condition, do not constitute a reconsideration of a previous decision. However, in any case where there is a request to retroactively change a past decision or the Board officer reconsiders a prior decision regarding health care, the restrictions on reconsideration apply.

- Vocational rehabilitation benefit entitlement – Consideration of entitlement to vocational rehabilitation services under section 16 may be required at various points during the claim to assist in a worker's recovery and return to work.

A decision to modify, replace or discontinue a rehabilitation plan is a new decision. Any subsequent decision regarding the worker's future entitlement to vocational rehabilitation services would also be a new decision with prospective application.

- A new matter may arise as a result of legislative provisions that expressly direct the WCB to make certain decisions or take certain actions at specified points in the claim. If the WCB fails to render these decisions or take these actions at the specified point, the Board officer must make the decision as soon as the error is discovered in order to fulfill the requirements of the *Act*. These decisions would have prospective application. For example, under section 33.1(2) of the *Act*, if a worker's disability continues for ten cumulative weeks of benefits, the WCB must determine the amount of average earnings of the worker based on the worker's gross earnings for the 12-month period immediately preceding the date of the injury.

(b) Implementation of Review Division Decisions or WCAT Decisions

On a review or an appeal, the Review Division and the WCAT may make a decision that confirms, varies or cancels the decision under review or appeal. The Review Division and WCAT decisions are final and must be complied with by the Board.

Varying or canceling a decision may make invalid other decisions that are dependent upon or result from the decision under review or appeal.

The reconsideration and reopening requirements under section 96 do not limit changes to previous decisions that are required in order to fully implement decisions of the Review Division or the WCAT.

PRACTICE

There is no PRACTICE for this Item.

EFFECTIVE DATE:	January 1, 2005
AUTHORITY:	ss. 96(2) - (7), 96.4(9), 255, <i>Workers Compensation Act</i>
CROSS REFERENCES:	Changing Previous Decisions - Reopenings (C14-102.01), Changing Previous Decisions - Reconsiderations (C14-103.01), Changing Previous Decisions - Fraud and Misrepresentation (C14-104.01), Changing Previous Decisions - Reviews (C14-105.01), Vocational Rehabilitation – Nature and Extent of Programs and Services (C11-88.00)
HISTORY:	Amendments effective January 1, 2005 to clarify the difference between a new decision and a change in a previous decision, and to provide guidance on the implementation of Review Division and WCAT decisions. New Item consequential to the <i>Workers Compensation Amendment Act (No. 2), 2002</i>
APPLICATION:	Applies to all decisions on and after January 1, 2005

**RE: Changing Previous Decisions –
Reopenings**

ITEM: C14-102.01

BACKGROUND

1. Explanatory Notes

The Board may, at any time, reopen a matter that has been previously decided by the Board or an officer or employee of the Board, if certain circumstances exist.

2. The Act

Section 96 states, in part:

.....

- (6) Despite subsection (1), any time, on its own initiative, or on application, the Board may reopen a matter that has been previously decided by the Board or an officer or employee of the Board under this Part if, since the decision was made in that matter,
 - (c) there has been a significant change in a worker's medical condition that the Board has previously decided was compensable, or
 - (d) there has been a recurrence of a worker's injury.

- (7) If the Board determines that the circumstances in subsection (2) justify a change in a previous decision respecting compensation or rehabilitation, the Board may make a new decision that varies the previous decision or order.

.....

POLICY

(a) General

The reopening of a previous decision does not affect the application of the decision to the period prior to the significant change in the worker's medical condition or the

recurrence of the worker's injury. Rather, it enables the Board to reopen matters previously decided and determine a worker's ongoing entitlement. A reopening involves the adjudication of new matters.

(b) A reopening is not a reconsideration

A reopening is to be distinguished from a reconsideration of a previous decision.

A reconsideration occurs when the Board considers the matters addressed in a previous decision anew to determine whether the conclusions reached about these matters reached were valid. Where the reconsideration results in the previous decision being varied or cancelled, it constitutes a redetermination of those matters.

(c) Grounds for reopening

A decision may be reopened if, since it was made:

- there has been a significant change in a worker's medical condition that the Board has previously decided was compensable; or
- there has been a recurrence of a worker's injury.

"A significant change in a worker's medical condition that the Board has previously decided was compensable" means a change in the worker's physical or psychological condition. It does not mean a change in the Board's knowledge about the worker's medical condition.

A "significant change" would be a physical or psychological change that would, on its face, warrant consideration of a change in compensation or rehabilitation benefits or services. In relation to permanent disability benefits, a "significant change" would be a permanent change outside the range of fluctuation in condition that would normally be associated with the nature and degree of the worker's permanent disability.

A claim may be reopened for repeats of temporary disability, irrespective of whether a permanent disability award has been provided in respect of the compensable injury or disease. A claim may also be reopened for any permanent changes in the nature or degree of a worker's permanent disability.

(d) Recurrence of injury

A recurrence of an injury may result where the original injury, which had either resolved or stabilized, occurs again without any intervening new injury. A recurrence of an injury may result in a claim being reopened for:

- an additional period of temporary disability benefits where no permanent disability award was previously provided in respect of the compensable injury;

- an additional period of temporary disability benefits where a permanent disability award was previously provided in respect of the compensable injury; and,
- an additional permanent disability award being provided due to a change in the nature and degree of the worker's permanent disability resulting from the original work injury.

An example of a recurrence of an injury is where a worker has a compensable injury for which temporary disability benefits are paid. The injury resolves and the claim is closed, but later becomes disabling again without any intervening new injury. In these situations it is considered that the original injury has recurred. The result is that the worker may be entitled to an additional period of temporary and/or consideration for permanent disability compensation under the original claim.

A recurrence of injury that entitles a worker to request a reopening of an existing claim is to be distinguished from a new injury that entitles the worker to make a new claim.

For example, where a compensable injury is aggravated by a second compensable injury, the first injury has not "recurred". Rather a new injury has occurred that will result in a new claim. The decision whether to reopen the existing claim or initiate a new claim will depend upon the evidence in each case.

The following types of questions may assist in determining whether there is a recurrence or a new injury:

- Have there been any intervening incidents, work-related or otherwise?
- Has there been a continuity of symptoms and/or continuity of medical treatment?
- Can the current symptoms be related to the original injury?

(e) Reopening on application or on own initiative

Section 96(2) sets out the two ways in which the Board may reopen a matter that has been previously decided by the Board: on its own initiative, or on application.

A request for a reopening of a previous decision will be considered on application where the worker refers specifically to section 96(2) of the *Act* or uses language substantially similar to that section. An application may be submitted to the Board in written or verbal form.

A reopening request will not be considered on application where:

- a worker makes a general request for additional wage-loss benefits, health care benefits, vocational rehabilitation services or permanent disability benefits;

- a worker makes a request for a reconsideration and/or the acceptance of a new injury or occupational disease;
- a request is made by a person other than the worker, employer or their authorized representative;
- information is submitted to the Board such as medical reports received from a worker's doctor; or
- the Board has made a decision to reopen a matter on its own initiative as part of the ongoing adjudication of a claim.

(f) Right to request a review

Section 96.2(2)(g) of the *Act* provides that no request may be made to a review officer under section 96.2(1) to review a decision to reopen or not to reopen a matter on an application for a reopening under section 96(2). Section 240(2) provides that a decision to reopen or not to reopen a matter on an application may be appealed directly to the Workers' Compensation Appeal Tribunal ("WCAT").

The effect of these provisions is that the preliminary or threshold question whether the grounds for a reopening on an application have been met under section 96(2)(a) and (b) may not be the subject of a review by a review officer. A party who wishes to dispute the Board's decision in this respect must appeal directly to the WCAT.

However, where a reopening consideration was undertaken on the Board's own initiative, a request for review of the decision is made to a review officer.

Once it is determined that the grounds for a reopening have been met, the Board's decision on the compensation or rehabilitation to be paid or provided as a result of the reopening may be the subject of a request for a review by a review officer under section 96.2(1). The review officer's decision may then be appealed to the WCAT under section 239(1).

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WCB website.

EFFECTIVE DATE: January 1, 2005
AUTHORITY: ss. 96(2), (3), *Workers Compensation Act*



WORKERS' COMPENSATION BOARD OF BC

REHABILITATION SERVICES & CLAIMS MANUAL

- CROSS REFERENCES:** Changing Previous Decisions - General (C14-101.01), Changing Previous Decisions - Reconsiderations (C14-103.01), Changing Previous Decisions - Fraud and Misrepresentation (C14-104.01), Changing Previous Decisions - Reviews (C14-105.01)
- HISTORY:** Amendments effective January 1, 2005 to clarify recurrence of injury and to distinguish between a reopening on application and a reopening on own initiative.
Amendments effective March 18, 2003 to clarify that a reopening allows compensation or rehabilitation benefits to be "varied" and that disputes over a decision to reopen or not to reopen a matter "on application" are appealable directly to WCAT under section 240(2).
New Item consequential to the *Workers Compensation Amendment Act (No. 2), 2002* approved effective March 3, 2003.
- APPLICATION:** Applies to all decisions on and after January 1, 2005

**RE: Changing Previous Decisions –
Reconsiderations**

ITEM: C14-103.01

BACKGROUND

1. Explanatory Notes

The *Act* provides the Board with a very limited time period to reconsider previous decisions or orders. Subject to certain restrictions, the Board may only reconsider a decision or order under Part 1 of the *Act* during the period of 75 days subsequent to the decision or order being made.

2. The Act

Section 1, in part:

“**reconsider**” means to make a new decision in a matter previously decided where the new decision confirms, varies or cancels the previous decision or order

Section 96, in part:

.....

- (8) Despite subsection (1), the Board may, on its own initiative, reconsider a decision or order that the Board or an officer or employee of the Board has made under this Part.
- (9) Despite subsection (4), the Board may not reconsider a decision or order if
 - (d) more than 75 days have elapsed since that decision or order was made,
 - (e) a review has been requested in respect of that decision or order under section 96.2, or
 - (f) an appeal has been filed in respect of that decision or order under section 240.

.....

POLICY

(a) Definition of reconsideration

A reconsideration occurs when the Board considers the matters addressed in a previous decision anew to determine whether the conclusions reached were valid. Where the reconsideration results in the previous decision being varied or cancelled, it constitutes a redetermination of those matters.

(b) The purpose of sections 96(4) and (5)

The Board's authority to reconsider previous decisions and orders is found in section 96(4) and (5) of the *Act*. These provisions result from legislative amendments that came into effect on March 3, 2003. The purpose of these amendments is to promote finality and certainty within the workers' compensation system.

The same amendments establish a right to request a review by a review officer under sections 96.2 to 96.5, where a party disagrees with a decision or order made at the initial decision-making level. It is this review, rather than the application of the Board's reconsideration authority, which is intended to be the dispute resolution mechanism for initial decisions and orders of Board officers.

It is significant that section 96(4) only authorizes the Board to reconsider a decision or order "on its own initiative". This is to be contrasted with the Board's authority to reopen a matter "on its own initiative, or on application" under section 96(2). It is also to be contrasted with section 96.5 and section 256, which authorize a review officer and the appeal tribunal, respectively, to reconsider decisions on application in certain circumstances.

The use of the words "on own initiative" in section 96(4), with no provision for "on application", and the availability of a review mechanism under sections 96.2 to 96.5, indicate that the Board is not intended to set up a formal application for reconsideration process to resolve disputes that parties may have with decisions or orders.

Rather, the Board's reconsideration authority is intended to provide a quality assurance mechanism for the Board. The Board is given a time-limited opportunity to correct, on its own initiative, any incorrect decisions it may have made.

(c) Advice to parties

Parties to a decision or order will be advised, in writing, at the time the decision or order is made, of the right to request a review of the decision or order under section 96.2. A party who approaches the Board to have the decision or order reconsidered will be reminded of the party's right to request a review under section 96.2. If the Board reconsiders a decision or order before the request for review is made, the Board will advise the parties to the decision or order of the reconsidered decision. The reconsidered decision gives rise to a new right to request a review under section 96.2.

(d) Restrictions on reconsideration

The *Act* places a number of express restrictions on reconsidering previous decisions and orders. It is noted, in this respect, that "reconsider" means the making of the new decision and not merely the starting of the reconsideration process leading to the new decision.

- The Board may not reconsider a decision or order more than 75 days after the decision or order was made. This includes all decisions of the Board and officers and employees of the Board made prior to March 3, 2003. The 75 day period commences on the date the decision was made (not March 3, 2003 in the case of those decisions made prior to that date).
- The Board may not reconsider a decision or order if a review has been requested in respect of that decision or order under section 96.2. A request for review under section 96.2 immediately terminates the authority of the Board to reconsider a previous decision or order, even if 75 days has not passed since the decision or order was made.
- The Board may not reconsider a decision or order if an appeal has been filed in respect of that decision or order under section 240. The filing of an appeal under section 240 immediately terminates the authority of the Board to reconsider the decision or order, even if 75 days has not passed since the decision or order was made.

There are, in addition, a number of implicit restrictions on reconsidering previous decisions and orders. The Board is not authorized to reconsider decisions or findings of the following bodies:

- the former Appeal Division, which existed prior to March 3, 2003;
- the former Commissioners, who existed prior to June 3, 1991;
- the boards of review and the Workers' Compensation Review Board, which existed prior to March 3, 2003; and
- the Board of Review, which existed prior to January 1, 1974.

Section 256 of the *Act* provides for the Workers' Compensation Appeal Tribunal to reconsider its own decisions and decisions of the former Appeal Division under certain limited conditions. The Legislature therefore "turned its mind" to the extent that former appellate decisions should be reconsidered and legislated its intent.

(e) Grounds for reconsideration

Subject to the limitations set out above, the Board may reconsider a decision on its own initiative where:

- there is new evidence indicating that a prior decision or order was made in error;
- there has been a mistake of evidence, such as:
 - material evidence was initially overlooked, or
 - facts were mistakenly taken as established which were not supported by any evidence or by any reasonable inference from the evidence;
- there has been a policy error such as:
 - applying an applicable policy clearly incorrectly, or
 - not applying an applicable policy; or
- there has been a clear error of law, such as a failure by the Board to follow the express terms of the *Act*.

(f) Authority of Board officers, Managers and Directors to reconsider

A Board officer may only reconsider a decision made by another Board officer where there is new evidence, a mistake of evidence, a policy error or a clear error of law.

A Manager or Director may reconsider a decision or order made by a Board officer in any of these circumstances, and may also reweigh the evidence and substitute his or her own judgment for that of the Board officer.

(g) Correction of administrative errors

The correction of an administrative error such as a clerical, typographical or mathematical error or an error in an agreed statement of facts does not result in a reconsideration of a previous decision. The ability to correct these types of errors, slips or omissions would not be considered a reconsideration of the original decision, as it would not change the intent of the original decision made by the Board officer.

The limits on reconsiderations of previous decisions do not prevent a Board officer from issuing an addendum to correct a clerical or typographical error in a decision. This may be done where the text of the decision did not correctly reflect the Board officer's intent. An example of a clerical error might include a Board officer incorrectly typing in a decision letter \$25,000 rather than \$52,000 for a worker's earnings, but it is clear from the evidence on the claim that this was a simple typographical error.

An accidental slip or omission may occur when the decision as recorded does not clearly reflect the intention of the decision-maker. For example, a decision letter states “I do accept the degenerative changes as part of the claim”, however; the remainder of the letter and the evidence on the claim clearly illustrate that the Board officer intended that the letter state “I do not accept”.

This process for correcting errors, slips or omissions, however, cannot be applied to change decisions.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WCB website.

EFFECTIVE DATE:	January 1, 2005
AUTHORITY:	ss. 96(4), (5), <i>Workers Compensation Act</i>
CROSS REFERENCES:	Changing Previous Decisions - General (C14-101.01), Changing Previous Decisions - Reopenings (C14-102.01), Changing Previous Decisions - Fraud and Misrepresentation (C14-104.01), Changing Previous Decisions - Reviews (C14-105.01)
HISTORY:	Amendments effective January 1, 2005 to include policy on the correction of administrative errors. New Item consequential to the <i>Workers Compensation Amendment Act (No. 2), 2002</i>
APPLICATION:	Applies to all decisions on and after January 1, 2005

