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Policy and Research Division

Mailing Address

PO Box 5350 Stn Terminal
Vancouver BC V6B 5L5

Location

6951 Westminster Highway
Richmond BC

Telephone 604 276-5160
Fax 604 279-7599

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Update 2007 – 4

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

This update of the *Rehabilitation Services & Claims Manual* contains amendments to the *Manual* implemented since update 2007 – 3.

This amendment includes a number of minor policy changes as part of the CMS project; **effective October 1, 2007.**

- Policy item #26.04, *Recognition by Oder Dealing with a Specific Case*
- Policy item #32.50, *“Date of Injury” for Occupational Disease*
- Policy item #48.41, *When Does an Overpayment of Compensation Occur?*
- Policy item #74.21, *Duration of Treatment*
- Policy item #77.30, *The Prescription of Narcotics and Other Drugs of Addiction*
- Policy item #79.00, *Clothing Allowances*

A summary of the amendments is attached and the amended pages are included as part of the package.

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

Local phone: 604-232-9704
Toll-free: 1-866-319-9704

Local fax: 604-232-9703
Toll-free fax: 1-888-232-9714

Roberta Ellis
Vice President
Policy and Research Division

Attachments

Rehabilitation Services & Claims Manual, Volume I

SUMMARY OF AMENDMENTS – Update 2007 – 4

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 Typhoid
 Vinyl Chloride Induced Raynaud's Phenomenon
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It is important to distinguish between designation or recognition of an occupational disease under section 6(4)(b) or by regulation of general application, and the addition of a disease to Schedule B under section 6(4)(a). Where the Board concludes that a disease is more likely to occur in connection with a particular employment covered by the Act than elsewhere, it may be added to Schedule B (see policy item #26.01). On the other hand, where the Board concludes that a disease is sometimes due to the nature of a particular employment covered by the Act, but it does not appear that the disease is more likely to occur in connection with that employment than elsewhere (it is not something specific to that employment), the Board may designate or recognize the disease under section 6(4)(b) or by regulation of general application without the rebuttable presumption afforded by inclusion in Schedule B.

Several of the above contagious diseases are not likely to be “. . . due to the nature of any employment in which the worker was employed . . .” except for hospital employees, or workers at other places of medical care.

The authority under the *Act* to designate or recognize a disease under sections 6(4)(a), 6(4)(b) or by regulation of general application rests with the Board of Directors.

EFFECTIVE DATE: February 11, 2003 (as to deletion of reference to the former Governors)
APPLICATION: Not applicable.

#26.04 Recognition by Order Dealing with a Specific Case

The lack of prior designation or recognition by the Board of a disease as an occupational disease by any of the means specified in policy items #26.01, #26.02, or #26.03, does not mean a claim for such disease will not be considered on its merits. Such disease may not have been previously designated or recognized due to weak or a complete absence of medical and scientific information which causally associates such disease with employment. If the merits and justice of an individual claim for such a disease warrant its recognition as an occupational disease, the Board may do so "by order dealing with a specific case" (section 1).

The effect of such an order is to accept the claim for compensation purposes without establishing an institutional memory for decision-makers or an expectation for others who may suffer from that disease that the disease may be due to the nature of some employment. In other words, the disease will be recognized as an occupational disease limited to the specific facts of that individual claim.

This allows an avenue of recognition for unique, meritorious, individual disease claims. As the Board repeatedly encounters such claims for a particular disease, it may determine that a higher level of designation or recognition is warranted for that disease.

An Adjudicator upon investigating an individual claim may find that the condition suffered by the worker is not one listed in the first column of Schedule B, nor is it one which has been previously designated or recognized by the Board as an occupational disease under section 6(4)(b) or by regulation. If the Adjudicator concludes, after seeking appropriate input from both the worker (or their legal representative) and the employer (if a specific employer is identified) that the facts warrant recognition of the worker's condition as an occupational disease, the Adjudicator will refer the claim with a recommendation to that effect to a panel made up of his or her Client Services Manager, (referred to in this section as the "Manager"), and a Board Medical Advisor (referred to in this section as the "Medical Advisor").

If, however, after seeking such input from the worker and employer, the Adjudicator concludes that the facts do not warrant recognition of the worker's condition as an occupational disease, the Adjudicator will disallow the claim without referring it to the panel, and will notify the worker and employer. This is a reviewable decision. The Adjudicator shall advise the Manager that the worker's condition is not one previously designated or recognized by the Board as an occupational disease, the nature of the condition, and the Adjudicator's decision to disallow the claim.

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

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

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

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

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

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

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

APPLICATION: Applies on or after October 1, 2007

#26.10 Suffers from an Occupational Disease

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

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

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

#26.20 Establishing Work Causation

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

There are two approaches to establishing work causation.

#26.21 Schedule B Presumption

Section 6(3) provides:

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

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

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

was concluded that there was insufficient evidence that employment, as opposed to other factors in the worker's life, were of causative significance in producing this condition. (16)

#32.50 "Date of Injury" for Occupational Disease

For purposes of establishing a wage rate on a claim for occupational disease (determining the average earnings and earning capacity of the worker at the time of the injury), the Adjudicator will consider the occurrence of the injury as the date the worker first became disabled by such disease. A worker will be considered disabled for this purpose when they are no longer able to perform their regular employment duties and as such would in the ordinary course sustain a loss of earnings as a result. This date may or may not correspond with the date the worker was first diagnosed with the occupational disease.

The date of the worker's first seeking treatment by a physician or qualified practitioner for the occupational disease is used for administrative purposes. For example, this date will be used where there is no period of disability. Where the worker's condition was not at that time diagnosed as an occupational disease, the relevant date is the date the occupational disease is first diagnosed. These dates may also, in the absence of evidence to the contrary, be used as the date of disablement for the purpose of determining compensation entitlement under Section 55 of the Act.

EFFECTIVE DATE: October 1, 2007 – Revised to delete reference to assigning a claim number.

APPLICATION: Applies on or after October 1, 2007

#32.55 *Time Limits and Delays in Applying for Compensation*

A person must apply for compensation for death or disablement due to an occupational disease within the time limits set out in Section 55 of the Act. That person can be the worker or the worker's dependant(s) if the worker has died. People who delay in applying for compensation may lose or limit their right to compensation because the Board can only consider an application on its merits if the requirements of Section 55 are met. One of the purposes of these time limits is to ensure the Board is given early notice of the claim so that the relevant evidence can be obtained when it is more readily available.

A person applying for compensation for an occupational disease must generally do so within one year of the date of death or disablement (in most cases a disablement will precede any death). There are exceptions as noted below. If the worker is alive and if the occupational disease has never caused a disablement, then time has not yet started to elapse for the purposes of Section 55. Section 55(2) says in part:

- (2) Unless an application is filed, or an adjudication made, within one year after the date of . . . death or disablement from occupational disease,

no compensation is payable, except as provided in subsection (3), (3.1), (3.2), and (3.3).

Under the terms of a predecessor to the current Section 55, a claim must be denied if a person applies to the Board more than one year after the worker's most recent disablement or after the worker's death if:

- the death occurred before January 1, 1974, or
- the most recent disablement occurred before January 1, 1974 and the exposure to the cause of the occupational disease in British Columbia did not continue beyond that date.

#32.56 Applicants Who File Within Three Years

The Board may consider paying compensation benefits even though a person applies more than one year after the death or disablement due to the occupational disease if:

- he or she applies within three years after the death or disablement, and
- special circumstances precluded applying within one year.

Section 55(3) says:

- (2) If the board is satisfied that there existed special circumstances which precluded the filing of an application within one year after the date referred to in subsection (2), the board may pay the compensation provided by this Part if the application is filed within 3 years after that date.

For a discussion of special circumstances, see #93.22.

If special circumstances do not exist, the Board cannot consider the claim, unless it meets Section 55(3.2), because the application will be out of time.

#32.57 Applicants Who File Beyond Three Years

A person who applies more than three years after the date of death or disablement due to the occupational disease might still receive compensation benefits under Section 55(3.1). If special circumstances precluded applying within one year, the Board may still consider starting compensation benefits from the date the Board received the application. However, the Board cannot consider compensation benefits for periods before that date, unless the claim meets Section 55(3.2).

Section 55(3.1) says:

(3.1) The board may pay the compensation provided by this Part for the period commencing on the date the board received the application for compensation if

- (a) the board is satisfied that special circumstances existed which precluded the filing of an application within one year after the date referred to in subsection (2), and
- (b) the application is filed more than 3 years after the date referred to in subsection (2).

As stated before, if special circumstances do not exist, the Board cannot consider the claim, unless it meets Section 55(3.2), because the application will be out of time.

#32.58 Newly Recognized Occupational Diseases

As noted in policy item #25.00, it is often more difficult to determine whether a person's employment caused a disease than to determine whether it caused a personal injury. Our knowledge about the role a particular kind of employment may have in causing various diseases changes over time. In recognition of this difficulty, part of section 55 applies only to claims for occupational disease.

The Board may consider paying compensation benefits for a death or disablement due to an occupational disease if all three of the following conditions apply:

1. At the time of the worker's death or disablement, the Board does not have sufficient medical or scientific evidence to recognize the disease as an occupational disease for this worker's kind of employment (even though the Board may have recognized it as an occupational disease for other kinds of employment).
2. The Board subsequently obtains sufficient medical or scientific evidence to cause it to recognize the disease as an occupational disease for this worker's kind of employment.
3. The application for compensation is made within three years after the date the Board recognized the disease as an occupational disease for this worker's kind of employment.

Section 55(3.2) says:

(3.2) The Board may pay the compensation provided by this Part if

- (a) the application arises from death or disablement due to an occupational disease,

- (b) sufficient medical or scientific evidence was not available on the date referred to in subsection (2) for the Board to recognize the disease as an occupational disease and this evidence became available on a later date, and
- (c) the application is filed within 3 years after the date sufficient medical or scientific evidence as determined by the Board became available to the Board.

If, after July 1, 1974, and before August 26, 1994, the Board has considered an application and has determined that all or part of the claim cannot be paid because of the wording of section 55 then in effect, the Board may now under section 55(3.3) reconsider the claim and pay compensation for those periods previously denied if it meets the requirements of section 55(3.2).

Section 55(3.3) says:

(3.3) Despite section 96(1), if, since July 1, 1974, the Board considered an application under the equivalent of this section in respect of death or disablement from occupational disease, the Board may reconsider that application, but the Board must apply subsection (3.2) of this section in that reconsideration.

For example, in the 1970s sufficient medical or scientific evidence was not available for the Board to recognize an association between exposure to coal tar pitch volatiles in aluminum smelters and an excess risk of bladder cancer. It was not until the late 1980s that sufficient evidence became available for the Board to recognize such an association. (However, the Board had earlier recognized that there was an association between bladder cancer and prolonged exposure to certain chemicals used primarily in the manufacture of rubber and dyes. In 1980 “primary cancer of the epithelial lining of the urinary bladder” was added to Schedule B, with a corresponding presumption in favour of causation where the worker had prolonged exposure to any of three listed chemicals.) On March 13, 1989, the Board issued a policy directive recognizing bladder cancer as an occupational disease for workers employed in aluminum smelting, dependent on the concentration and length of exposure to coal tar pitch volatiles.

Section 55(3.2) allows the Board to consider the payment of compensation benefits for any worker disabled by bladder cancer who was exposed to sufficient doses of coal tar pitch volatiles while employed in the aluminum smelting industry if:

- the exposure did not end before January 1, 1974, and
- the Board received the application not later than March 13, 1992.

Section 55(3.3) allows the Board to reconsider any claims for bladder cancer that meet the requirements of section 55(3.2) and to pay compensation for any periods previously denied because of the wording of the earlier section 55 in effect since July 1, 1974. Sections 55(3.2) and (3.3) went into effect on August 26, 1994. If a claim for bladder cancer is filed after March 13, 1992, then the requirements of sections 55(2), (3), or (3.1) must be met before compensation can be paid.

EFFECTIVE DATE: March 3, 2003 (as to new wording of section 55(3.3))
APPLICATION: Not applicable.

#32.59 Discretion to Pay Compensation

As stated in policy item #93.22, even though special circumstances may have precluded the filing of the application within one year, the Board has discretion under section 55 whether or not to pay compensation. In exercising that discretion, the Board considers whether the time elapsed since the death or disability due to the occupational disease has prejudiced its ability to investigate the merits of the claim, including determining whether the worker was disabled from earning full wages at the work at which he or she was employed.

The Board considers the availability of evidence, such as:

- medical records about the worker's state of health at relevant times (cause of death in the case of a deceased worker)
- employment records that may document exposures to contaminants or hazardous processes, or periods of disability that may have been due to the occupational disease
- evidence from co-workers or others who may know about the worker's employment activities.

The Board will generally decide not to pay compensation if so much time has elapsed that it cannot reasonably obtain sufficient evidence to determine whether:

- the worker's disease was causally connected to the employment, or
- the worker was disabled by the disease when claimed.

A request for review by the Review Division may be made on a Board decision not to pay compensation.

Where a worker has experienced more than one period of disablement from the occupational disease for which the worker intends to claim, then each period of disablement will have to be individually considered to determine if the requirements of section 55 are met with respect to that period.

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

#32.60 Preventive Measures and Exposures

Once the basic requirements of a claim for a compensable injury or occupational disease have been met, the Board can accept responsibility for reasonable preventive or curative measures which are a normal part of the treatment of the resulting condition. For example, if a nurse pricks his or her finger with a contaminated hypodermic needle, just used for injecting a patient suspected of having infectious hepatitis, the Board will pay for a gamma globulin injection. This would be so even if the actual needle prick itself did not require treatment.

In order for an exposure to a disease or contaminant to be compensable, the worker must either sustain a personal injury or suffer from an occupational disease. An exposure which does not result in a personal injury or occupational disease does not meet the requirements of the Act in terms of compensability. Section 1 provides that "occupational disease" includes "*disablement* resulting from exposure to contamination" (emphasis added). No matter how appropriate it may be for a worker to be provided with prophylactic health care, particularly following an exposure to an infectious agent, the Board does not have the statutory authority to pay for such health care where the worker has not sustained a personal injury or is suffering from an occupational disease, even if the exposure places the worker at risk for developing an occupational disease.

In the event of such an exposure, any medical or other expenses that the worker may incur to prevent the onset of an injury or disease must remain the responsibility of the worker or the employer. For example, the Board would not pay for a measles vaccine for a nurse who came in contact with a patient who had that disease. In those circumstances, the nurse has not sustained either a personal injury nor an occupational disease. In one case, a laboratory assistant accidentally spilled over a hand blood from a patient infected with hepatitis. The worker already had an infected hangnail on that hand. The Board could not accept responsibility for the subsequent treatment with gamma globulin as there was no evidence of the worker suffering an injury or occupational disease. The treatment was for the purpose of preventing the onset of a disease.

It may help to further illustrate these principles. The Board would not pay for preventive health care benefits with respect to the following exposures (unless an occupational disease results):

- an ambulance attendant who has the blood of a suspected Hepatitis B carrier splashed onto a hand which had pre-existing cuts from gardening at home;
- a pipefitter who unknowingly works in an area containing asbestos insulation.

(d) **Rehabilitation Allowances**

The Ministry has agreed not to request an Assignment of Benefits from rehabilitation allowances paid under Section 16 of the *Workers Compensation Act*.

3. Where no payments of compensation on the claim are due after receipt of the assignment or the payments cease before the full amount owed to the Ministry is paid off, the Ministry is advised that it will have to collect the amount outstanding through other means.

The claimant is advised when welfare payments are being deducted from workers' compensation benefits.

#48.23 *Requirements to Pay*

The Board may receive written notice requiring that benefits owing to a worker be redirected, in whole or in part, to the Federal Receiver General on account of the worker's debt under the *Income Tax Act* or the *Excise Tax Act*. Such a notice is referred to as a "Requirement to Pay". The Board will comply with Requirements to Pay.

EFFECTIVE DATE: July 13, 2005

APPLICATION: Benefits, including retroactive awards of benefits, payable under the *Workers Compensation Act* on or after July 13, 2005.

#48.30 Worker Not Supporting Dependents

Where a worker is not supporting the worker's wife or husband and the worker's children and they are likely to be a charge upon the municipality where they reside, or where an order has been made against the worker by a court of competent jurisdiction for the support or maintenance of the worker's wife, husband or family, the Board may divert such compensation in whole or in part from the worker for the benefit of the worker's wife, husband or children. (1)

As the administration and payment of social assistance allowances is now a responsibility of the Provincial Government, a spouse or children not being supported by a worker are unlikely to become a charge on the municipality where they reside. Where, however, a request is received to divert compensation payments under the authority of Section 98(4), it must be supported by a Court Order. An exception might occur where, due to some unusual, unforeseen circumstances, the worker's spouse or children are in fact likely to become a charge on a municipality where they reside.

Where compensation is being diverted under this provision, any Consumer Price Index adjustments are apportioned between the payment made to the worker and the diverted payment.

The Board will comply with Notices of Attachment issued under Sections 8 and 9 of the *Family Maintenance Enforcement Act*.

#48.40 Overpayments/Money Owed to the Board

Section 15 provides an exception to its general prohibition of assignments, charges or attachments of compensation benefits in respect of “money owing to the accident fund”. The Board may therefore deduct from compensation benefits the amount of money owed to it by the person entitled to receive them.

A claimant or employer may owe money to the Board in several ways. They may be paid more compensation benefits than they are entitled to as a result of an administrative error, a decision outside the statutory authority of the Board, or fraud or misrepresentation. (See #48.41.) They may incur liability for the repair or replacement of Board property which they damage. An employer or independent operator may fail to pay assessments owed to the Board.

Assessments owing by a limited company may be deducted from compensation payments made to the sole principal of that company or, where there is more than one principal, from payments made to a principal who is personally responsible for the non-payment of assessments. (2) This also applies to situations involving personal optional protection premiums owing.

#48.41 When Does an Overpayment of Compensation Occur?

An overpayment is any money paid out by the Board to a payee as a result of an administrative error, fraud or misrepresentation by the worker, or where the decision was not one within the statutory authority of the Board. Administrative errors are mechanical, mathematical, or an error in implementing a decision on a claim, and similar types of errors. They do not include decisions made regarding entitlement. An overpayment may also be incurred by a doctor, qualified practitioner, or an institution following the incorrect payment of a health care benefit account by the Board.

A decision regarding entitlement which is modified or reversed by a later decision does not result in an overpayment. These are referred to as “Decisional Errors” and include errors of policy. They include situations where new information is later received which initiates a judgment change in the original decision. They can also include situations where information was available but overlooked, or a missed wage rate change.

Decisional errors involving actions outside the statutory authority of the Board or due to fraud or misrepresentation are corrected retroactively to the date of the original decision, and result in an overpayment.

Board policy also does not require the initiation of recovery procedures for overpayments under \$50.00 as long as there is no evidence of fraud or misrepresentation. All overpayments, irrespective of the amount, are referred to the Board's Legal Services Division where fraud or misrepresentation is indicated.

EFFECTIVE DATE: October 1, 2007 – Revised to remove reference to computer errors.

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

APPLICATION: Applies on or after October 1, 2007

#48.42 *Recovery Procedures for Overpayments*

If, at the time of the discovery of the overpayment, payments are still being made on the claim, the amount of any overpayment will be recovered from those payments. The Board officer will as far as possible do this in a manner which causes the least hardship to the worker. Normally, the Board officer will recover the amount owing by instalments. If payments of the claim are terminated by the time the overpayment is discovered or before full recovery can be obtained, the procedures outlined below are followed. However, if a request for a review by the Review Division or an appeal to the Workers' Compensation Appeal Tribunal against the overpayment is lodged, re-collection procedures are as outlined in policy item #48.46.

1. The Vocational Rehabilitation Services and Claims Departments will conduct the initial collection procedure which will include the Board officer making personal contact with the claimant in addition to sending two letters, one immediately and one 30 days later. For overpayments in excess of \$500, the second letter advises that unpaid accounts will be turned over to the Board's Collections Section.
2. When the overpayment is 70 days overdue it will be sent to the Board's Collections Section. Unless there is evidence of fraud or misrepresentation, claims for overpayments under \$500 are not sent to Collections.
3. A letter will be sent to the claimant by a Collections Officer at the 70-day overdue date indicating that the overpayment has been transferred to the Board's Collections Section and suggesting that payment be made within a month in order to avoid possible legal action. This letter

will make it clear that the Board is serious about collecting the overpayment.

4. If payment is not received within 30 days, or a reasonable payment plan arranged, the Collections Officer will attempt to make telephone contact with the claimant or pay a personal visit.
5. If this does not result in positive arrangements for payment, a final, more strongly worded letter will be sent. An asset search will be conducted and if there is a reasonable expectation that money is collectible, the account will be turned over to the Board's Legal Services Division for attention and action. The result of this action could be the seizing of assets or garnisheeing wages.

Policy item #50.00 sets out the procedures regarding the crediting of interest to retroactive wage-loss and pension payments. In the case of claims overpayments, interest charges only apply to amounts due where the overpayment is the result of fraud, misrepresentation or the withholding of information by the worker. Interest is not charged on overpayments that result from the correction of an error. The charging of interest on an overpayment must be approved by a Manager or a Director.

In the case of doctors and other health care benefit payees, overpayments are handled by the Board by making a deletion from future payments. There is no attempt by the Board to obtain the recovery of such an overpayment from a worker who received the health care benefits unless the costs of the health care benefits were paid directly to the worker.

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

APPLICATION: Not applicable.

#48.43 *Recovery of Overpayments on Reopenings or New Claims*

If there is an outstanding overpayment made to a worker on a claim and that claim is reopened or a new claim for the same worker is established, the overpayment will be recovered from that worker. Normally, this will take place following contact with the worker to determine the manner in which the overpayment is to be recovered, either in full from the first payment of wage loss, or where the overpayment is a considerable sum of money, at a reasonable amount every two weeks during the period of disability. Every attempt will be made to recover the full amount of the overpayment.

Where there is an outstanding overpayment to either the worker or the employer and the claim is reopened or a new claim established, and if the worker is still employed by the same employer and they continue full salary, the overpayment will be recovered in full from that employer before subsequent wage loss is paid to them. The employer will be notified that this process is taking place. No recoveries are made from workers for overpayments made to employers.

Subject to the exception referred to in the preceding paragraph, the recovery of overpayments will be made only from those to whom the overpayment is made.

The general law of bankruptcy releases a bankrupt from all claims provable in bankruptcy upon discharge from bankruptcy. Therefore, where an overpayment has been incurred prior to the bankruptcy date, the Board does not take legal proceedings against the discharged bankrupt to recover the overpayment. Should a subsequent claim be submitted or the claim reopened, no attempt to recover such an overpayment is made.

#48.44 Deduction of Overpayments from Pensions

Where a worker is entitled to a permanent partial disability award, attempts are made to recover the overpayment prior to establishing the award. Whenever possible, the full amount will be recovered direct from the worker. Where recovery is not made prior to the payment of the award, the recovery may be made from the award itself either from the initial payment or on the basis of a pension adjustment as follows:

- (a) non-payment of the full pension for a fixed term;
- (b) a partial reduction of the pension for a fixed term;
- (c) a partial reduction of the pension for life.

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

Where a previous pension award has been made and the overpayment is on a subsequent claim, the Board does not usually elect to recover the overpayment from the prior pension award. This is an option that is only used as a last resort. The choice is first given to the worker as to how she or he wishes to repay the overpayment on the understanding that the Board would prefer not to interfere with the ongoing pension.

Where a pension has been suspended for the purpose of paying off an amount owing to the Board, the claimant will, every six months, be sent a statement showing the results of any changes in the pension amount because of Consumer Price Index adjustments, the amounts credited to the claimant's account as a result of the suspension, and the amount still owing.

Pensions to workers and dependants are paid to the end of each calendar month. Should a worker or dependant die during the month for which a full month's payment has been made, no deduction is made nor is any overpayment declared.

#48.45 Deduction of Overpayments from Rehabilitation Payments

An overpayment may be recovered from a rehabilitation assistance payment at the discretion of the Rehabilitation Consultant in consultation with the Claims Adjudicator or Claims Officer. Every attempt is, however, made by the Board to have the claimant make arrangements to repay the overpayment in some other method rather than reduce a rehabilitation payment. Recovery from a rehabilitation payment would only occur under exceptional circumstances.

#48.46 Reviews and Appeals on Overpayments

A request for a review by the Review Division may be made on the question of whether the claimant owes money to the Board and, if so, the amount owing. However, no such request may be made on the question of whether the Board should recover the overpayment or not, and on the manner of any recovery. Board policy requires that if an overpayment is being reviewed or appealed, procedures to recover the overpayment from the worker will be suspended pending the decision by the Review Division or the Workers' Compensation Appeal Tribunal. However, if a new claim is submitted, or a claim other than the one on which the request for review by the Review Division or the appeal to the Workers' Compensation Appeal Tribunal is recorded is reopened, recoveries of the overpayment may be made from any benefit entitlements that accrue. The Board officer will of course still be permitted to exercise discretion as to the amount and the periodic nature of the recovery.

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

APPLICATION: Not applicable.

#48.47 Waiver of Overpayment Recoveries

Other than the exceptions listed in #48.41, it is the Board's position that recoveries should be made when an overpayment occurs. As such, it is expected that requests to waive recovery should be rare and must clearly meet policy criteria.

Board policy regarding the waiver of recovery procedures for overpayments provides for the following:

The President, Vice-President, Compensation Services Division (or Directors for overpayments under \$1,000) will have discretionary authority to waive recovery procedures for overpayments where:

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

#74.20 Chiropractors

#74.21 Duration of Treatment

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

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

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

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

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

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

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

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

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

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

APPLICATION: Applies on or after October 1, 2007

#74.22 *Scope of Chiropractic Treatment*

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

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

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

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

Table 1

1. Analgesic Target Drugs

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

2. Sedative-Hypnotic Drugs

- (a) Barbiturates
- (b) Meprobamate

3. Tranquilizers

- (a) Diazepam
- (b) Chlordiazepoxide

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

APPLICATION: Applies on or after October 1, 2007

#78.00 DIRECTION, SUPERVISION, AND CONTROL OF HEALTH CARE

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

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

#78.10 Direction, Supervision, and Control of Treatment

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

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

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

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

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

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

#78.32 *Reversal of Decision on Review or Appeal*

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

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

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

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

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

APPLICATION: Not applicable.

#78.33 *Form Fees*

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

Where a claim is rejected, that is, where:

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

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

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

#79.00 CLOTHING ALLOWANCES

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

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

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

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

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

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

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

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

APPLICATION: Applies on or after October 1, 2007

#80.00 PERSONAL CARE EXPENSES OR ALLOWANCES

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

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

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

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

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

#80.10 Levels of Personal Care Allowances

There are five levels of personal care allowances:

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

Examples are:

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

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

This includes:

Paraplegia with bowel and bladder functions impaired.

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

Examples are:

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

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

Examples are:

High lesion quadriplegia or severe head injuries.

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

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

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

#80.20 Amounts Payable at Each Level

The amounts of personal care allowances are set out below.

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

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

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

#80.30 Payment Procedure

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

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

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

#80.40 Claimant Requires Institutional Care

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

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

#81.00 INDEPENDENCE AND HOME MAINTENANCE ALLOWANCE

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

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

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

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

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

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

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

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

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

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

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

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

#82.00 TRANSPORTATION ALLOWANCES

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

#82.10 Eligibility for Transportation

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

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

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

Transportation expenses are not normally paid in regard to:

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

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

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

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

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

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

APPLICATION: Not applicable.

#82.11 *Worker Bypasses Nearby Medical Facilities*

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

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

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

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

#82.20 **Amount of Reimbursement**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#82.30 Manner of Payment

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

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

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

#82.40 Transportation Provided by the Employer

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

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

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

#82.50 Flight Changes

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

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

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

#83.00 SUBSISTENCE ALLOWANCES

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

#83.10 Eligibility for Subsistence

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

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

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

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

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

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

#83.11 *Travelling Companions*

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

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

Approval for these visits is recorded on the claim and requires approval from the Amputee Group Physician and the Manager of the Rehabilitation Centre¹ or their delegates.

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

¹ The "Claims Department" no longer exists.

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

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

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

#83.12 Visits Home by Worker

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

#83.13 Income Loss

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

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

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

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

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

#83.20 Rates of Subsistence

"Subsistence" means the costs of accommodation and meals.

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

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

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

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

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

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

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

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

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

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

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

#84.00 REHABILITATION RESIDENCE

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

#84.10 Eligibility For Admittance

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

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

The following categories for Residence admission eligibility have been established.

#84.11 Rehabilitation Centre Treatment

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

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

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

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

#84.12 Medical Consultation or Disability Evaluation

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

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

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

#84.13 *Rehabilitation Programs*

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

A. Rehabilitation Centre Vocational Assessment Programs

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

B. Training and Education Programs

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

#84.14 *Rehabilitation Residence Filled*

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

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

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

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

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

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

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

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

#84.30 Visits to and from Home

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

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

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

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

#84.40 Conduct of Worker at the Rehabilitation Residence

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

#84A.00 HOMEMAKERS SERVICES

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

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

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

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

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

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

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

The allowance will normally be paid to the claimant.