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August 2006

Update 2006 – 6

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

This update of the *Rehabilitation Services & Claims Manual* contains amendments to the *Manual* implemented since update 2006 – 5.

This update includes amendments to the following:

- Chapter 1, *Scope of Volume II of This Manual*
- Chapter 9, *Average Earnings*

Also included are housekeeping changes to:

- Chapter 4, *Compensation for Occupational Disease*
- Chapter 12, *Claims Procedures*
- Chapter 17, *Charging of Claim Costs*
- Appendix 4, *Permanent Disability Evaluation Schedule*

A summary of the amendments is attached and the amended pages are included as part of the package, **effective August 1, 2006**.

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Roberta Ellis
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Attachments

Rehabilitation Services & Claims Manual, Volume II
SUMMARY OF AMENDMENTS – Update 2006 – 6

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Chapter 1	Pages 3 – 8	Policy item #1.03, <i>Scope of Volume I and II in Relation to Benefits for Injured Workers</i>
Chapter 4	Pages 1 – 2	Policy item #25.00, <i>Introduction</i>
Chapter 9	Pages 19 – 40	Policy items #68.61, <i>Workers Deducting Business and/or Equipment Expenses</i> and #68.62, <i>Fishers</i>
Chapter 12	Pages 19 – 22	Policy item #96.10, <i>Policy of the Board of Directors</i>
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#1.03 *Scope of Volumes I and II in Relation to Benefits for Injured Workers*

(a) **General**

Subject to subsequent amendments, Volume I sets out the law and policies that were in effect immediately prior to June 30, 2002 in relation to compensation for injured workers. For convenience, the law and policies in effect immediately prior to that date, as amended, will be called the “former provisions”.

Volume II sets out the law and policies in effect on or after June 30, 2002, as they may be amended from time to time, in relation to worker benefits. For convenience, the law and policy on or after that date, including any subsequent amendments, will be called the “current provisions”.

Unless otherwise stated, in Volume II of this *Manual* the “*Act*” refers to the *Workers Compensation Act*, as amended on or after June 30, 2002. The *Interpretation Act*, RSBC 1996, Chapter 238, applies to the *Act*, unless a contrary intention appears in either the *Interpretation Act* or the *Act*.

(b) **Amendment Act, 2002 (Bill 49) Transitional Provisions**

The following rules apply to determining whether the former provisions (Volume I) or the current provisions (Volume II) apply in a particular case. These rules are based upon the transitional rules in section 35.1 of the *Workers Compensation Act*, as amended by the *Amendment Act, 2002*.

1. The current provisions apply to an injury that occurs on or after June 30, 2002.
2. Except as noted in rules 3, 4, and 5, the former provisions apply to an injury that occurred before June 30, 2002.
3. Subject to rule 4 respecting recurrences, if an injury occurred before June 30, 2002, but the first indication that it is permanently disabling occurs on or after June 30, 2002, the current provisions apply to the permanent disability award with two modifications:
 - (i) 75% of average earnings (former provisions) is used for calculating the award rather than 90% of average net earnings (current provisions); and
 - (ii) no deduction is made for disability benefits under the Canada Pension Plan (former provisions).

Under this rule, for an injury that occurred before June 30, 2002, where the first indication of permanent disability also occurs before June 30, 2002, the permanent disability award will be adjudicated under the former provisions. Where the first indication of permanent disability is on or after June 30, 2002, the award will be adjudicated under the current provisions, using the modified formula described in (i) and (ii) above. The determination of when permanent disability first occurs will be based on available medical evidence.

An example of when this rule applies is where a worker, injured before June 30, 2002, shows no signs of permanent disability before that date. However, on or after June 30, 2002, the worker has surgery, which first causes permanent disability. The permanent disability award will be adjudicated under the current provisions, using the modified formula.

4. If an injury occurred before June 30, 2002, and the disability recurs on or after June 30, 2002, the current provisions apply to the recurrence.

This transitional rule applies only to a recurrence of a disability on or after June 30, 2002. It does not apply to permanent changes in the nature and degree of a worker's permanent disability. Where a worker was entitled to a permanent disability award before June 30, 2002 in respect of a compensable injury or disease, the former provisions apply to any changes in the nature and degree of the worker's permanent disability after that date.

For the purposes of this policy, a recurrence includes any claim that is re-opened for an additional period of temporary disability, regardless of whether the worker had been entitled to a permanent disability award before June 30, 2002. However, where the worker was entitled to a permanent disability award before June 30, 2002, the former provisions apply to any changes in the nature and degree of the worker's permanent disability following an additional period of temporary disability.

The following are examples of a recurrence:

- A worker totally recovers from a temporary disability resulting in the termination of wage-loss payments. Subsequently, there is a recurrence of the disability and the claim is re-opened for compensation.
- A worker is in receipt of a permanent partial disability award and the disability subsequently worsens so that the worker is

temporarily totally disabled. The claim is re-opened to provide compensation for a new period of temporary disability. The additional period of temporary disability is a recurrence to which the current provisions apply. However, a subsequent change in the nature and degree of the worker's permanent disability is adjudicated under the former provisions.

5. Regardless of the date of injury, the current provisions on indexing apply to compensation paid for an injured worker on or after June 30, 2002. Indexing of retroactive awards payable before June 30, 2002 will be based on the former provisions.

EFFECTIVE DATE: August 1, 2006

APPLICATION: Amendments to policy item #1.03(b)(4) that took effect on August 1, 2006 apply to all decisions, including appellate decisions, made on or after October 16, 2002.

HISTORY: December 31, 2003 – Amendments to reflect consequential changes to the *Act* resulting from the *Amendment Act, 2003*.

June 17, 2003 – Reorganization of format and addition of content to address the scope of Volumes I and II of the Manual.

October, 16, 2002 – Amendments to clarify meaning of "recurrence" for the purposes of section 35.1(8) of the *Act*.

#1.10 The Persons Covered by the Act

Not everyone is entitled to compensation under the *Act*, even if injured at work. To qualify for compensation, a person must be a "worker" employed by an employer covered by the *Act*. (1) Where a compensable injury or disease results in the worker's death, certain of the worker's relatives are entitled, but they must usually have been "dependants" during the worker's lifetime. (2)

#1.20 The Conditions under which Compensation is Payable

Not all injuries or diseases are compensable. The *Act* prescribes the type of injuries (3) and diseases (4) and the circumstances in which they are compensable. (5) Thus, for example, in the case of injuries, compensation is limited to personal injuries arising out of and in the course of employment. (6)

#1.30 The Type and Amount of Compensation

There are a variety of types of compensation provided under the *Act*:

1. payments to compensate the injured worker for loss of earnings caused by a temporary disability; (7)
2. permanent disability awards for actual or estimated loss of earnings; (8)
3. pensions to dependants for loss of support by a deceased worker; (9)
4. health care benefits; (10)
5. rehabilitation assistance. (11)

#1.40 Charging of Claims Costs

The cost of compensation is normally charged to the employer rate group to which the worker's employer belongs. The cost may also affect the employer's experience rating. There are special provisions which relieve the rate group and/or the employer in certain situations. (12)

#2.00 WORKERS' COMPENSATION BOARD

The Workers' Compensation Board is a corporation set up under the *Act* to administer the provisions of the *Act*. (13) The *Act* defines the word "Board" as the Workers' Compensation Board. (14) The use of the word "Board" throughout this *Manual* means the Workers' Compensation Board.

The Board of Directors must set and revise as necessary the policies of the Board of Directors, including policies respecting compensation, assessment, rehabilitation and occupational health and safety. The Board of Directors must set and supervise the direction of the Board.

EFFECTIVE DATE: February 11, 2003 (as to deletion of references to the Appeal Division and the former Governors)

APPLICATION: Not applicable.

#2.10 Jurisdiction over Claims Adjudication

The Board has exclusive jurisdiction to inquire into, hear, and determine all matters and questions of fact and law arising under the *Act*, and the action or

decision of the Board thereon is final and conclusive and is not open to review in any Court. (17) Thus, the Board has sole jurisdiction over the adjudication of claims for compensation under the *Act*.

EFFECTIVE DATE: February 11, 2003 (as to deletion of references to the Appeal Division and the former Governors)

APPLICATION: Not applicable.

#2.20 Application Of The *Act* And Policies

In making decisions, Board officers must take into consideration:

1. the relevant provision or provisions of the *Act*;
2. the relevant policy or policies in this *Manual*; and
3. all facts and circumstances relevant to the case.

By applying the relevant provisions of the *Act* and the relevant policies, Board officers ensure that:

1. similar cases are adjudicated in a similar manner;
2. each participant in the system is treated fairly; and
3. the decision-making process is consistent and reliable.

Section 99(2) of the *Act* provides that:

The Board must make a decision based upon the merits and justice of the case, but in so doing the Board must apply a policy of the board of directors that is applicable in the case.

In making decisions, Board officers must take into account all relevant facts and circumstances relating to the case before them. This is required, among other reasons, in order to comply with section 99(2) of the *Act*. In doing so, Board officers must consider the relevant provisions of the *Act*. If there are specific directions in the *Act* that are relevant to those facts and circumstances, Board officers are legally bound to follow them.

Board officers also must apply a policy of the Board of Directors that is applicable to the case before them. Each policy creates a framework that assists and directs Board officers in their decision-making role when certain facts and circumstances come before them. If such facts and circumstances arise and there is an applicable policy, the policy must be followed.

All substantive and associated practice components in the policies in this *Manual* are applicable under section 99(2) of the *Act* and must be followed in decision-

making. The term “associated practice components” for this purpose refers to the steps outlined in the policies that must be taken to determine the substance of decisions. Without these steps being taken, the substantive decision required by the Act and policies could not be made.

References to business processes that appear in policies are only applicable under section 99(2) of the *Act* in decision-making to the extent that they are necessary to comply with the rules of natural justice and procedural fairness. The term “business processes” for this purpose refers to the manner in which the Board conducts its operations. These business processes are not intrinsic to the substantive decisions required by the *Act* and the policies.

If a policy requires the Board to notify an employer, worker, or other workplace party before making a decision or taking an action, the Board is required to notify the party if practicable. “If practicable” for this purpose means that the Board will take all reasonable steps to notify, or communicate with, the party.

This policy item is not intended to comment on the application of practice directives, guidelines and other documents issued under the authority of the President/Chief Executive Officer of the Board. The application of those documents is a matter for the President/CEO to address.

EFFECTIVE DATE: March 3, 2003
APPLICATION: To all adjudication decisions made on or after the effective date

CHAPTER 4

COMPENSATION FOR OCCUPATIONAL DISEASE

#25.00 INTRODUCTION

Section 6 of the *Act* provides that compensation is payable for occupational disease that is due to the nature of a worker's employment. Section 7 provides that compensation is payable for a certain level of non-traumatic noise-induced hearing loss that results from a worker's employment. A worker's entitlement to compensation for a total or partial disability resulting from a loss of hearing is paid in accordance with the compensation provisions set out in Part 1 of the *Act*. This chapter deals with such compensation.

Most compensation cases involve a personal injury (covered in Chapter 3) where it can readily be determined whether the event or series of events leading to such injury arose out of and in the course of employment. The cause of disease, by its nature, is often more difficult to determine. A common difficulty is distinguishing between an injury and a disease (the difference is discussed in policy item #13.10). Even when medical science has identified the cause of a disease in a general sense, it may be difficult to establish with any degree of certainty how and when a worker contracted or developed a disease. Further, workers' compensation does not extend to all diseases, rather only to those that are due to a worker's employment. In these circumstances, determining the extent to which a worker's employment had a role in producing the disease becomes a critical or central issue.

The question is: was the worker's disability caused by his or her work or by something else such as the operation of natural causes, or by congenital or hereditary disease. The *Act* provides different ways of dealing with this issue. These are discussed in this chapter.

#25.10 Legislative Requirements

Section 6(1) provides:

Where

- (a) a worker suffers from an occupational disease and is thereby disabled from earning full wages at the work at which the worker was employed or the death of a worker is caused by an occupational disease; and

- (b) the disease is due to the nature of any employment in which the worker was employed, whether under one or more employments,

compensation is payable . . . as if the disease were a personal injury rising out of and in the course of that employment. A health care benefit may be paid although the worker is not disabled from earning full wages at the work at which he or she was employed.

For the diseases to which section 6(1) of the *Act* apply, there are three basic requirements for compensability:

1. The worker must be suffering (or in the case of a deceased worker have suffered) from a disease designated or recognized by the Board as an “occupational disease”;
2. The disease suffered by the worker must be or have been “due to the nature of any employment” in which the worker was employed; and
3. The worker must be “disabled from earning full wages at the work” at which he or she was employed as a result of the disease. In the case of a deceased worker, his or her death must have been caused by such disease. This is discussed further in policy item #26.30. This third requirement does not apply to claims for silicosis, asbestosis, or pneumoconiosis (see policy item #29.40) or to claims for non-traumatic noise-induced hearing loss to which section 7 of the *Act* apply. Further, a worker need not be disabled by the disease in order to be entitled to health care benefits.

These elements of section 6 are discussed further in the following sections. The definition of “worker” is covered in Chapter 2.

A disease which is attributed to or is the consequence of a specific event or trauma, or to a series of specific events or traumas, will be treated as a personal injury and will be adjudicated in accordance with the policies set out in Chapter 3.

#26.00 THE DESIGNATION OR RECOGNITION OF AN OCCUPATIONAL DISEASE

Section 1 of the *Act* defines “occupational disease” as

any disease mentioned in Schedule B, and any other disease which the Board, by regulation of general application or by order dealing with a specific case, may designate or recognize as an occupational disease, and “disease” includes disablement resulting from exposure to contamination (emphasis added).

#68.50 Property Value Losses

No account will be taken of losses in property values alleged to be the result of the work injury, for example, where the injured person is disabled from working on and improving land which the person owns or there is a loss of goodwill in the business because of an inability to work in it.

#68.60 Payments in Respect of Equipment

Any portion of the wages paid to a worker which represents rental of equipment supplied by her or him is excluded from average earnings.

#68.61 Workers Deducting Business and/or Equipment Expenses

Section 33(1) of the *Act* provides that the Board must determine a worker's average earnings with reference to the "worker's average earnings and earning capacity at the time of the worker's injury."

A worker's earnings may include payment for business expenses or costs associated with equipment. Such a worker's average earnings are calculated based on the labour component of the worker's earnings, which is the portion of the earnings that remains after deductions for business expenses and/or costs associated with equipment.

This policy enables the Board to determine the labour component of a worker's earnings where the worker receives payment for providing services, out of which the worker must pay for any business expenses and/or costs associated with equipment that is a required component of the contract of service. Such equipment is normally required to fulfill the contract, and represents a portion of the worker's costs in providing the service.

Generally, where a worker may deduct business expenses and/or costs associated with equipment from his or her earnings for business or tax purposes, this suggests that the worker's earnings include payment in respect of such costs and/or expenses. This policy does not apply to a worker receiving separate special expense reimbursements or allowances from an employer; the Board considers such payments under policy item #68.23 *Special Expenses or Allowances*.

(a) Short-Term Average Earnings

Business expenses (that is, expenses not associated with equipment) are generally not considered in a worker's short-term average earnings.

To calculate short-term average earnings for a worker who for business or taxation purposes deducts costs associated with equipment, the Board does not consider the worker's actual costs at the time of the injury.

The Board determines the labour component of such a worker's short-term average earnings by applying a percentage that represents the costs of supplying the appropriate category of equipment from the worker's date of injury earnings, set out as follows:

(i) Light Equipment

Where light equipment is supplied, the gross figure will be converted to gross wages by applying the following percentages.

Equipment	Wages
15%	85%

Examples of light equipment include chain saws, lawn mowers, and portable welding equipment and compressors not permanently mounted on vehicles.

(ii) Medium Equipment

Where medium equipment is supplied, the gross figure will be converted to gross wages by applying the following percentages.

Equipment	Wages
40%	60%

Examples of medium equipment include motor vehicles used for pilot car or local delivery services, and minor excavating equipment (e.g. two-wheel drive agriculture-type tractors, complete with backhoe attachments and/or front-end loader attachment).

(iii) Heavy Equipment

Where heavy equipment is supplied, the gross figure will be converted to gross wages by applying the following percentages.

Equipment	Wages
75%	25%

Examples of heavy equipment include logging trucks, skidders, bulldozers, and line haul trucks.

(b) Long-Term Average Earnings

In calculating the long-term average earnings of a worker who for business or taxation purposes deducts business expenses and/or costs associated with equipment, the Board decides which costs and/or expenses will be deducted from gross earnings to determine the labour component of the worker's gross earnings.

In determining whether the Board will deduct a business expense or a cost associated with equipment from a worker's gross earnings, the Board considers the following questions as appropriate:

- 1) Did the worker's gross earnings for the time period under review include payment in respect of the expense?
- 2) Did the worker incur the expense directly as a result of supplying equipment and/or materials to the employer?
- 3) Did the expense result from the worker operating his or her business?
- 4) Would the worker incur the expense regardless of the nature of the employment?

To calculate the amount the Board will deduct as an expense for equipment depreciation, the worker will be asked to provide the purchase price for any equipment that is a required component of the contract of service. The purchase price of such equipment is usually the invoiced value of the asset(s), including applicable taxes. Where a worker trades in another asset in order to purchase a new asset, the trade does not reduce the value of the acquired asset for the purposes of determining the purchase price.

The capital cost allowance or depreciation amount for equipment that is a required component of the contract of service will be deducted from gross earnings where it does not exceed 15 percent of the purchase price of the equipment.

Where the capital cost allowance or depreciation amount exceeds 15 percent of the purchase price, 15 percent of the purchase price will be deducted from gross earnings instead of the capital cost allowance or depreciation amount.

Where the worker does not declare a capital cost allowance or a depreciation amount for equipment that is a required component of the contract of service, the Board will not make a deduction for equipment depreciation from gross earnings for that equipment.

Interest accrued (whether paid or not) as the result of debt in respect of equipment owned by a worker that is a required component of the contract of

service is considered a business expense. The accrued interest is deducted from gross income.

EFFECTIVE DATE: August 1, 2006

APPLICATION: The revised policy applies to injuries that occur on or after August 1, 2006.

#68.62 Fishers

Generally, where a fisher may deduct business expenses and/or costs associated with equipment from his or her earnings for business or tax purposes, this suggests that the fisher's earnings include payment in respect of such costs. In calculating the earnings of a fisher who, for business or taxation purposes, deducts business expenses and/or costs associated with equipment, the Board decides which costs and/or expenses will be deducted from gross earnings to determine the labour component of the fisher's gross earnings. This policy does not apply to a fisher receiving separate special expense reimbursements or allowances from an employer; the Board considers such payments under policy item #68.23 *Special Expenses or Allowances*.

In determining whether the Board will deduct a business expense or a cost associated with equipment from a fisher's gross earnings, the Board considers the following questions as appropriate:

- 1) Did the fisher's gross earnings for the time period under review include payment in respect of the expense?
- 2) Did the fisher incur the expense directly as a result of supplying equipment and/or materials for fishing activities?
- 3) Did the expense result from the fisher operating his or her business?
- 4) Would the fisher incur the expense regardless of the nature of the employment?

To calculate the amount the Board will deduct as an expense for equipment depreciation, the fisher will be asked to list the purchase price of the vessel or the other equipment used to harvest fish. The purchase price of a vessel or equipment used to harvest fish is the invoiced value of the asset(s), including applicable taxes. Where a fisher trades in an equipment asset in order to purchase a new equipment asset, the trade does not reduce the value of the acquired equipment asset for the purposes of determining the purchase price.

The capital cost allowance or depreciation amount for a vessel or equipment used to harvest fish will be deducted from gross earnings where it does not exceed 15 percent of the purchase price of the equipment.

Where the capital cost allowance or depreciation amount exceeds 15 percent of the purchase price, 15 percent of the purchase price will be deducted from gross earnings instead of the capital cost allowance or depreciation amount.

Where the fisher does not take a capital cost allowance or a depreciation amount for a vessel or equipment used to harvest fish, the Board will not perform a deduction for equipment depreciation from gross earnings for that equipment.

Interest accrued (whether paid or not) as the result of debt in respect of a fishing vessel used and owned by a commercial fisher is considered a business expense. The accrued interest is deducted from gross income.

The purchase of food as a business expense is not deducted from gross income as it is considered a direct benefit to the fisher and is a measurable return from the activities of fishing. The costs of maintenance for the vessel or other equipment used to harvest fish, fuel, fishing nets, and other appropriate costs are deducted from gross income as costs associated with equipment. See also policy item #65.03.

EFFECTIVE DATE: August 1, 2006

APPLICATION: The revised policy applies to injuries that occur on or after August 1, 2006.

#68.70 Payments to Substitutes

A worker may be partially able to perform the normal work or work full-time at other types of work, but pay a substitute to carry out jobs which the worker is unable to do. Compensation will still be paid in respect of the payment to the substitute but only to the extent of the difference between the value of the work being performed by the worker and the lesser of the worker's average net earnings and the statutory maximum. Where the value of that work exceeds the worker's average net earnings or the statutory maximum, no compensation is paid.

Where the worker is a principal of a limited company, the amount paid to a substitute may be one indication of the principal's pre-injury earnings level if these earnings are not otherwise clearly ascertainable because, for example, earnings have consisted of sporadic withdrawals from the income or profits of the corporation. If the principal continues to work in the business after the injury while employing a substitute to carry on part of the pre-injury functions, the amount paid to the substitute may, in comparison with the pre-injury earnings, be a factor in computing the value of the principal's post-injury work. Regard would, however, also have to be had to the nature and extent of the principal's activities after the injury compared with before the injury and the continued income received from the business after allowing for the costs of operation.

Where a worker has personal optional protection, benefits are calculated without regard to the fact that the worker is employing a substitute to do all the pre-injury work.

#68.80 Government Sponsored Work Programs

A variety of payment systems are currently in use for work programs, such as:

1. The simple continuation of Employment Insurance, Welfare or other benefits.
2. A “top-up” of Employment Insurance, Welfare or other benefits. Full payment by the employer, subsidized either in whole or in part from Employment Insurance, Welfare or other government funds.

In cases of this type, the composition of average earnings is made up of the total dollar amount being paid to the worker either by the employer or the sponsoring government agency or a combination of either.

#68.90 Principals – Composition of Earnings

In determining average earnings of principals of companies for compensation purposes, regard is primarily had to the earnings rate reported by the employer. Where the principal receives nominal or no wages for the work done the Board will estimate what it considers to be a reasonable wage for that work.

If reported earnings are being received by a principal’s or shareholder’s spouse or child, then it should normally be considered for compensation purposes that the earnings belong to the spouse or child and not the principal or shareholder. The same applies if information of this nature has been provided on Income Tax Reports.

In making reports of this nature for Income Tax purposes, the company is asserting that the principal’s or shareholder’s spouse or child did work in the business and did earn the money paid. The Board is required to consider any evidence which may show that this assertion is incorrect and to make its own determination. However, the Board is entitled to rely upon this assertion unless there is good evidence to the contrary. Even if, upon investigation, the evidence shows that the spouse or child did not work for the company, that in itself does not mean that the payments to the spouse or child were earnings of the principal or shareholder. There could be any number of other reasons why the company might make payments to the spouse or child.

In compensating the principal of a small limited company, the Board’s obligations extend only to the losses suffered in the capacity of employee. Wage-loss compensation cannot be paid to reflect any detrimental effect that the injury may have on the company’s business.

#69.00 **MAXIMUM AMOUNT OF AVERAGE EARNINGS**

Section 33(3) provides that a worker's average earnings cannot exceed the "maximum wage rate".

The *Act* contains a special procedure for determining the maximum wage rate in force in any year. Section 33(7) provides that "Prior to the end of each calendar year, the board must determine the maximum wage rate to be applicable for the following calendar year." The maximum wage rate to be determined under subsection (7) is an amount that the Board thinks represents the same relationship to the sum of \$40,000 as the annual average of wages and salaries in the province for the year preceding that in which the determination is made bears to the annual average of wages and salaries for the year 1984; and the resulting figure is rounded to the nearest \$100. (10) For the purpose of determining annual average of wages and salaries under subsection (8), the Board may use data published or supplied by Statistics Canada. (11) Prior to 1986, the *Act* referred to \$11,200 and 1972 as the factors in the formula for calculating the maximum.

For the maximum wage rates in force used to calculate temporary and permanent disability payments, see below.

	Yearly Applicable
January 1, 2005 – December 31, 2005	\$61,300.00
January 1, 2006 – December 31, 2006	\$62,400.00

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

The maximum wage rate is not subject to consumer price index adjustments. Nor can a worker who is in receipt of the current maximum compensation benefits receive the benefit of such adjustments. However, if the maximum wage rate is increased in any year, workers injured in a prior year who were limited by the maximum compensation for that year can receive the benefit of any applicable cost of living adjustments occurring after the increase. Such adjustments are calculated using the previous maximum as a base and cannot at any time increase the worker's compensation above the current maximum.

Increases in the maximum wage rate do not have the effect of increasing the existing compensation being paid to workers whose payments have been limited by the lower maximum existing in a previous year. An exception to this rule may occur when, on a reopening occurring more than three years after the injury, the Board exercises its authority under section 32 to base compensation payments on the worker's earnings at the time of the reopening. (12)

Authority to approve increases in the maximum wage rate under section 33 has been assigned to the President.

#69.10 Deduction of Permanent Disability Periodic Payments from Wage Loss

Section 31(1) provides as follows:

Where a worker is receiving compensation for a permanent or temporary disability, the worker must not receive compensation for a further or other disability in an amount that would result in the worker receiving in the aggregate compensation in excess of the maximum payable for total disability.

Where a worker is entitled to wage-loss payments at the current maximum, and is in receipt of a permanent disability award under a previous claim, the permanent disability award is deducted from the wage-loss payments. If the wage-loss payments are less than the current maximum only the amount in excess of the maximum when the permanent disability award and wage loss are added together is deducted.

For calculating the amount of a deduction, the daily rate of the permanent disability award must be determined and then deducted from the daily rate of wage-loss compensation in the manner set out in policy item #70.10.

The deduction made under section 31 must be reviewed on each January 1 following the injury. This is to allow for possible cost of living adjustments to the amount of the permanent disability award and the wage loss and, with regard to January 1, changes in the maximum wage rate. For the purpose of section 31, the relevant maximum is the one applying in the year in which the wage-loss payment is being made.

For the deduction from wage loss of permanent disability awards under the same claim, reference should be made to policy items #70.00, #70.10, and #70.20.

#69.11 *Permanent Disability Award Cash Awards and Term Permanent Disability Awards*

Section 31(2) provides:

Where a worker has received a lump sum in lieu of the periodic payments that otherwise would have been payable for a permanent disability, the worker is, for the purposes of subsection (1), deemed to be still in receipt of the periodic payments.

Where a worker is entitled to receive wage-loss benefits on a new claim and has received a lump-sum payment on any prior claim (in lieu of a monthly permanent disability periodic payment), the permanent disability award will be deducted only to the extent that it is necessary to ensure that the worker does not receive in the aggregate more than the current maximum.

In the case of a reopening of the same claim within three years, any previous lump-sum payment (in lieu of a permanent disability periodic payment) will be deducted from the current daily wage-loss payments. The same position exists in respect of reopenings of the same claim after three years where the claimant's pre-injury earnings are used to calculate benefits. Where, however, in the case of a reopening after three years, current earnings are used under the terms of section 32(1), any previous lump-sum payment (in lieu of a permanent disability periodic payment) will be deducted in accordance with section 32(2).

Where there is a recurrence after three years and a term permanent disability award remains applicable and is being considered for its significance under section 32(2), the term permanent disability award should be converted to a notional life value for that purpose.

While the question whether a lump-sum payment is deducted is determined by its monthly equivalent at the time of the commutation, the amount actually deducted is the monthly equivalent at the time the deduction is made. The amount available for deduction includes cost of living adjustments which have occurred since the commutation was granted.

#70.00 AVERAGE EARNINGS ON REOPENED CLAIMS

#70.10 Disability Occurring Within Three Years of Injury

Where a claim is reopened for temporary total or temporary partial disability within three years of the date of injury (or the equivalent date in the case of occupational diseases), the wage rate set on the claim at the time of the injury is the rate to be used. In applying this policy, where the wage rate was set before June 30, 2002, the wage rate for a recurrence must be reset in order to convert it from a rate based on 75% of gross average earnings to a rate based on 90% of average net earnings. This conversion will involve using wage information from the time of the injury plus applicable cost of living adjustments and the relevant tax provisions at the time of recurrence.

This could be either the original rate or the rate review figure if such an adjustment has occurred.

Any permanent disability award granted under the same claim is deducted from the amount of the payments. A permanent disability award that has been granted on another claim is deducted only to the extent that the combined total of wage-loss and permanent disability periodic payments exceeds the current maximum. Cost of living adjustments are made if applicable.

Where a permanent partial disability award is being paid on the same claim, the wage-loss payments are calculated as the difference between the total compensation benefits and the permanent partial disability periodic payments in the following manner:

1. The annual permanent disability payment amount is calculated by multiplying the monthly figure by 12.
2. The annual permanent disability payment amount is divided by the working days per year to obtain a daily rate.

5-day week = 261 days

5-1/2-day week = 287 days

6-day week = 313 days

7-day week = 365 days

3. The daily permanent disability payment amount is deducted from the daily wage-loss payment. (13)

Where required under the *Act*, if a 10-week rate review has not already been carried out on the claim, it will be done by the Board officer following the reopening at the earlier of: when the total wage loss paid on the claim adds up to ten weeks or the effective date of a permanent disability award.

EFFECTIVE DATE: October 16, 2002

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

#70.20 Reopenings Over Three Years

Section 32 of the *Act* provides:

- (1) For the purpose of determining the amount of compensation payable where there is a recurrence of temporary total disability or temporary partial disability after a lapse of 3 years following the occurrence of the injury, the Board may calculate the compensation as if the recurrence were the happening of the injury if it considers that by doing so the compensation payable would more nearly represent the percentage of actual loss of earnings suffered by the worker by reason of the recurrence of the injury.
- (2) Where a worker has been awarded compensation for permanent partial disability for the original injury and compensation for recurrence of temporary total disability under subsection (1) is calculated by reference to the average earnings of the worker at the date of the recurrence, the compensation must be without deduction of the compensation payable for the permanent partial disability; but the total compensation payable must not exceed the maximum payable under this Part at the date of the recurrence.
- (3) Where more than three years after an injury a permanent disability or an increased degree of permanent disability occurs, the compensation payable for the permanent disability or increased degree of permanent disability may be calculated by reference to the average earnings of the worker at the date of the occurrence of the permanent disability or increased degree of permanent disability.

Section 32 of the *Act* gives the Board discretion to determine compensation benefits on a reopening of a claim more than three years after an injury by reference to the worker's current earnings.

The guidelines set out below apply in situations where there is a recurrence of temporary disability or an occurrence of or increase in a permanent disability over three years after an injury or disablement from occupational disease.

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

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

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

1. **Temporary Disability Recurring After Three Years Where the Worker Is Employed**

(a) **Worker's Current Earnings Exceed the Rate Originally Set On the Claim**

Where the worker's earnings at the time of the recurrence of disability exceed the earnings rate originally set on the claim (or the review rate, if applicable) plus cost of living adjustments, section 32(1) is normally applied so as to treat the recurrence of disability as the happening of the injury. Wage-loss compensation is based on the worker's earnings immediately prior to the recurrence and, where there is an existing permanent partial disability award granted in respect of the original injury, section 32(2) applies. Therefore, the permanent disability periodic payment is not deducted from the wage-loss benefits except to the extent that the combined total exceeds the maximum wage rate in effect at the time of the recurrence. (14) Where required under the *Act*, a 10-week rate review will be carried out. Any cost of living adjustments following the recurrence will be applied in accordance with section 25 of the *Act*.

(b) **Worker Is Employed at the Same Rate as Originally Set On the Claim**

Where the worker is employed at the same rate as originally set on the claim (or review rate, if applicable), the previous rate will be used plus applicable cost of living adjustments. The discretion contained in section 32(1) will not be exercised.

(c) **Worker Is Employed at a Lower Rate than Originally Set On the Claim**

Where the worker is employed at a lower rate than the rate originally set on the claim (or review rate, if applicable) plus

applicable cost of living adjustments, a determination will be made as to the reason for the lower figure.

(i) **Reduced Earnings Due to Effects of the Injury or Disease Accepted On the Claim**

If it is determined that the reduced earnings level is due to the effects of the injury or disease accepted on the claim, the rate originally set on the claim (or review rate, if applicable) plus applicable cost of living adjustments will be used on the reopening. Care must be exercised in making this determination to ensure that consistency is maintained with prior decisions reached on the claim. If, for example, a prior decision has been reached that a permanent disability award or higher award which the worker asked for should not be awarded because the worker was capable of undertaking certain occupations, it will not now be possible to conclude that the worker's not being employed in those occupations is due to the effects of the injury.

(ii) **Reduced Earnings Due to Personal Choice**

If it is determined that the lower earnings level is due to a matter of personal choice on the part of the worker, such as, for example, a voluntary change in lifestyle, the reduced earnings figure will be used on reopening to calculate the worker's wage rate. Section 32 will be applied and the rules set out in (a) above will apply in relation to the reduced figure.

(iii) **Reduced Earnings Due to Employment Situation**

If it is determined that the reduced earnings at the time of the reopening are due to employment difficulties occasioned by economic circumstances, section 32 applies and the recurrence of disability is treated as the happening of the injury. Where there is an existing permanent partial disability award granted in respect of the original injury, section 32(2) applies and the award is not deducted from the wage-loss benefits except to the extent that the combined total exceeds the maximum wage rate in effect at the time of the recurrence. The current rate of earnings will be used. When required by the *Act*, a 10-week rate review is carried out. Since the 10-week review

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

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

2. Temporary Disability Recurring After Three Years Where the Worker Is Unemployed

Where the worker is unemployed at the time of the reopening, a determination will be made of the reasons for this.

(a) Where Unemployed Status Is Due to the Effects of the Injury or Disease

If it is determined that the unemployed status prior to the recurrence is due to the effects of the injury or disease accepted on the claim, the wage rate originally set on the claim (or the review rate, if applicable) plus applicable cost of living adjustments will be used. The discretion in section 32 will not be exercised. As in 1(c)(i) above, care must be exercised to ensure that the determination is consistent with prior decisions on the claim.

(b) Where Unemployed Status Is Not Due to Effects of the Injury or Disease

If it is determined that the worker's unemployed status prior to the recurrence is not due to the effects of the injury or disease accepted on the claim, no wage-loss benefits are payable unless the disability following reopening will produce a potential for loss of income by removing the worker as a viable entity in the labour force. In the latter case, benefits will be paid on the basis of the wage rate originally set on the claim (or the review rate, if applicable) plus applicable cost of living adjustments. In determining whether there is a "potential loss", the following are among the questions that might be considered.

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

- (ii) Does the worker's lifestyle render it unlikely that he or she will, in practice, obtain employment? For example, if the worker has moved to a remote area where there are virtually no employment opportunities, this would indicate that there was no potential loss.
- (iii) Are there any other health conditions or personal problems that limit the possibility of employment?
- (iv) Was the worker being paid Employment Insurance benefits? Since the payment of such benefits requires a confirmation that the worker is fit for work, this would be an indicator that there was a potential loss.
- (v) Has the worker been making an active, ongoing, job search? Has the worker registered with the Human Resources and Development Commission?
- (vi) Has the worker maintained union status, remained available for dispatch to jobs, been dispatched to jobs or declined offers of dispatch?
- (vii) Was the worker listed as seeking employment by the Ministry of Human Resources?

3. Permanent Disability Occurring or Increasing More Than Three Years After Injury

The rules set out above in relation to wage-loss benefits are, in general, equally applicable to permanent disability awards. These rules have the effect that in one situation no wage-loss benefits are paid, notably when the worker is unemployed otherwise than through the effects of the injury and it is determined that there is no potential loss of earnings. A permanent disability award assessed on a loss of function basis under section 23(1) of the *Act* should, however, be paid in that situation and (subject to any appropriate wage rate review being carried out) calculated on the basis of the wage rate originally set on the claim plus applicable cost of living adjustments. Permanent disability awards are distinguishable from wage-loss benefits since the awards concern the long term situation as opposed to the current situation. Refer to Chapter 6, Permanent Disability Awards, for a discussion regarding the methods of assessing permanent disability awards. A permanent disability award is payable under section 23(1) for significant impairments even though the worker has returned to work with no

loss of earnings and may not have a loss of earnings in the future. Even though a person is unemployed at the time of a section 23(1) assessment, and does not now foreseeably have an actual loss of earnings, it does not mean that the person should not receive an award under section 23(1). However, the situation is different for projected loss of earnings awards under section 23(3). Since that assessment aims to predict the worker's actual loss of earnings over the future, no award can be made when the worker is unemployed for reasons unrelated to the injury and it is determined that there will not be a potential loss of earnings.

4. **Prior Occasion When Section 32 Was Applied**

Where, on a previous reopening of the claim, section 32 or its predecessor has been used to base compensation on the current earnings, any rate resulting from the application of that section is ignored for the purposes of a later reopening.

Where, according to the guidelines set out above, compensation would normally be based on the worker's pre-injury earnings, but it is found impossible or impractical to obtain those earnings, section 32(1) or (3) may be applied, unless this will result in a rate of compensation significantly less than that to which the pre-injury earnings would probably have entitled the worker.

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

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

- Where the person has maintained personal optional protection coverage at the time of reopening, the Board will determine the person's average earnings based on the current rate of coverage.
- Where the person no longer has personal optional protection, the Board will determine average earnings based on the initial personal optional protection rate plus the appropriate cost of living adjustments.
- Where the person is now employed in circumstances where there is compulsory coverage for worker so that the person is considered to be a worker under the *Act*, the rate on reopening will be based on the worker's current average earnings. An evaluation is required as to the impact of the original injury on the worker's current average earnings where the worker's average earnings are lower than the amount of personal optional protection the worker had at the time of the injury.

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

#70.30 Permanent Disability Awards

The Board's policy with respect to a reopening of claims after three years, where a pension cash award or term pension is involved, is as described in policy item #69.11.

#71.00 AVERAGE NET EARNINGS

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

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

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

- (a) probable EI premiums;
- (b) probable CPP contributions; and
- (c) probable income taxes.

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

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

#71.10 Short-term Average Net Earnings

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

- (a) the date temporary disability benefits have been payable to the worker for a cumulative period of 10 weeks; or
- (b) the effective date of a permanent disability award.

Schedule of Deductions

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

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

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

Probable CPP and EI

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

Probable Income Taxes

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

- (a) credits based on the basic personal amounts, multiplied by 1.5; and
- (b) credits for the probable CPP contributions and EI premiums payable for the worker’s average earnings.

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

#71.20 Long-term Average Net Earnings

Under section 33.9 of the *Act*, long-term average net earnings apply to the period commencing on the earlier of:

- (a) the first day after the date temporary disability benefits have been payable to the worker for a cumulative period of 10 weeks; or
- (b) the effective date of a worker's permanent disability award.

Formulas for Deductions

Effective January 1st each year, the Board implements formulas, based on those used by the Canada Customs and Revenue Agency, to calculate long-term average net earnings. The formulas reflect the federal and provincial income tax rates and the levels of CPP contributions and EI premiums in effect for the immediately preceding calendar year. As a result, any changes to these items during a calendar year are not incorporated into the formulas until January 1st of the following year.

When calculating long-term average net earnings, the Board uses the formulas to determine the CPP contributions, EI premiums and income taxes applicable to a worker's average earnings.

When calculating a worker's long-term average net earnings, the Board uses the formulas in effect on the earlier of the first day after the date temporary disability benefits have been payable to the worker for a cumulative period of 10 weeks; or the effective date of a worker's permanent disability award.

Probable CPP and EI

Deductions for probable CPP contributions and EI premiums are determined in a similar manner as for short-term average net earnings. When determining these deductions, the Board considers the contributions and premiums required under the *Canada Pension Plan Act* and the *Employment Insurance Act* for the worker's average earnings. The Board does not consider the actual CPP contributions and EI premiums deducted from the worker's paycheque.

Probable Income Taxes

In estimating the worker's probable income taxes, the Board allows only the following tax credits as determined under the *Income Tax Act* and the *Income Tax Act (Canada)*:

- (a) credits based on the basic personal amounts;

- (b) credits for EI premiums and CPP contributions; and
- (c) spousal credit or wholly dependent person credit and/or infirm dependant credit.

When establishing income tax credits for dependants, the Board will assume that the dependants have no income. As a result, where the worker qualifies for any of the credits under item (c) above, the worker will receive the maximum amount under the *Income Tax Act* or the *Income Tax Act (Canada)* for that credit.

Exceptions

Workers who are not required to pay CPP contributions under the *Canada Pension Plan Act* or EI premiums under the *Employment Insurance Act* do not have these probable contributions or premiums deducted from their average earnings when long-term average net earnings are established. For instance, workers under the age of 18 years do not have probable CPP contributions deducted, as these workers do not contribute under the *Canada Pension Plan Act*. As well, independent operators who do not pay into the EI scheme do not have probable EI premiums deducted when long-term average net earnings are calculated.

Workers who are not required to pay income taxes under the *Income Tax Act* or the *Income Tax Act (Canada)* do not have probable income taxes deducted when the Board calculates their long-term average net earnings. For example, workers who have Registered Indian Status under the *Indian Act (Canada)* and work on a reserve do not pay taxes on their employment income. As a result, no deductions for probable income taxes will be made when calculating the long-term average net earnings of these workers.

#71.30 Insufficient Information

A worker has an obligation under section 57.1 of the *Act* to provide the Board with the information that the Board considers necessary to administer the worker's claim. Where a worker fails to comply with this obligation, the Board may reduce or suspend payments to the worker until the worker complies. The worker's obligation to provide information is discussed in policy item #93.26.

Where the Board has insufficient information about a worker's tax status at the time that long-term average net earnings are calculated, the Board will assume that only the basic personal credits under the *Income Tax Act* and the *Income Tax Act (Canada)* apply.

In addition, where the Board has insufficient information about whether a worker is required to pay contributions under the *Canada Pension Plan Act* or premiums under the *Employment Insurance Act*, the Board will assume that the worker is required to pay those contributions or premiums.

#71.40 Adjustments

The Board may adjust a worker's average net earnings where they were based upon incorrect information. If the adjustment results in a decrease in the net value of the worker's earnings, the Board officer will consider policy item #48.41 in determining whether to declare an overpayment. If it results in an increase, a retroactive adjustment will be made.

NOTES

- (1) See policy item #34.40
- (2) See policy item #34.20
- (3) See policy item #65.04
- (4) See policy items #34.20; #35.23; #37.20; #39.60
- (5) See Item AP1-2-3 of the *Assessment Manual*
- (6) See Item C8-56.00 and Item C8-56.40
- (7) See Item AP1-1-5 of the *Assessment Manual*
- (8) See Item AP1-3-1 of the *Assessment Manual*
- (9) See policy item #34.40
- (10) s.33(10)
- (11) s.33(9)
- (12) See policy item #70.20
- (13) See policy item #69.00
- (14) See policy item #69.10

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

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

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

#95.40 Obligation to Advise and Assist Worker

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

EFFECTIVE DATE: December 31, 2003.

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

#96.00 THE ADJUDICATION OF COMPENSATION CLAIMS

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

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

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

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

#96.10 Policy of the Board of Directors

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

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

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

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

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

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

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

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

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

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

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

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

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

APPLICATION: Not applicable.

#96.20 Board Officers

A Board officer determines whether compensation is payable. They will decide, for instance, whether a worker was employed in an industry under Part 1 of the *Act*, whether a personal injury was suffered arising out of and in the course of employment, or whether the worker is suffering from an occupational disease which is due to the nature of the employment.

Following acceptance of a claim, the Board officer determines the amount and duration of compensation to be paid for temporary disability.

In a case of death, the Board officer decides whether the death is compensable and whether the members of the worker's family are dependants and entitled to compensation.

The term "compensation" includes, among other things, health care benefits, transportation and subsistence.

The Board officer determines when temporary total disability or temporary partial disability benefits are concluded, and whether an actual or potential permanent disability is accepted on the claim. These decisions are generally made on the basis of information supplied by a treating physician, qualified practitioner, consulting specialist and/or the injured worker. Treating physicians and qualified practitioners are required to send periodic reports to the Board outlining the worker's condition and restrictions.

A decision is provided to the worker, setting out whether an actual or potential permanent disability is accepted on the claim.

If an actual or potential permanent disability is accepted on the claim, the Board officer will refer the file to the Disability Awards Department for assessment. As part of the referral, the Board officer will prepare a memo, clearly setting out the status of the claim and confirmation of what permanent conditions have been accepted.

If the Board officer determines that there is no actual or potential permanent disability, the worker may request a review of the decision.

EFFECTIVE DATE: July 2, 2004

APPLICATION: Applies to all decisions, including appellate decisions, made on or after July 2, 2004.

2. the Board is satisfied that the form of oath which a person called to give evidence declares to have a binding effect on his or her conscience is not such that it can be taken in the place where the inquiry is being held, or that it is not fitting so to do, and the Board so directs,

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

#98.26 *Witnesses and Other Evidence*

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

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

#98.27 *Cross-examination*

Under the inquiry system (contrary to the adversary system), there is no right of cross-examination of the parties or witnesses. If, in the process of an inquiry, one of the parties wishes to ask a question of the person whose evidence is being taken, the question should be referred to the interviewer conducting the inquiry who, in turn, can relay the question if it is felt it would be helpful.

Cross-examination may, however, sometimes be permitted.

#99.00 **DISCLOSURE OF INFORMATION**

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

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

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

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

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

Before a review or appeal is initiated, the Board must apply *FIPPA* to requests for claim information. A request by a worker should be directed to a Manager in the appropriate Service Delivery Location. The Manager will comply with the request in accordance with the *FIPPA* rules. Before a review or appeal is initiated, an employer is not entitled to a copy of the worker's claim file. Disclosure to an employer in such circumstances, is limited to that information necessary for the adjudication or administration of the claim, that is on a "need to know" basis. Once a review or appeal has been initiated, full disclosure is available to either a worker or an employer. These disclosure rules are considered to be in accordance with *FIPPA* and the rules of natural justice.

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

Dispute Resolution

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

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

EFFECTIVE DATE: March 3, 2003 (as to the provision of copies of records related to a matter under review or appeal)
APPLICATION: Not applicable.

#99.10 Disclosure of Issues Prior to Adjudication

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

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

Written authorization is required in order to release information to any advocate, representative or other person designated by the worker or employer. Once received, the Board will cooperate with and notify workers' or employers' advocates or representatives of any decisions which have been made and communicated to the worker or employer.

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

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

#99.20 Notification of Decisions

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

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

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

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

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

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

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

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

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

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

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

#99.21 Notification of Rights of Review and Appeal

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

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

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

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

#99.22 Procedure for Handling Complaints or Inquiries About a Decision

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

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

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

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

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

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

#99.23 Unsolicited Information

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

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

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

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

7. If only some of the information is accurate and only some of the accurate information is relevant or potentially relevant to the administration of the worker's claim, the record that initiated the investigation will be destroyed and reference will only be made on the worker's claim to information that is both accurate and relevant or potentially relevant.
8. If, during the investigation, accurate information is discovered that is unrelated to the subject matter of the unsolicited information, but is relevant to the administration of the worker's claim, that information will be recorded separately on the worker's claim.
9. Where unsolicited information is found to be accurate and relevant or potentially relevant to the administration of the worker's claim, the worker will be advised of the information and given an opportunity to comment. Complaints about the accuracy and relevancy of unsolicited information will be dealt with according to policy item #99.35 - Complaints Regarding File Contents.

#99.24 *Notification of Permanent Disability Awards*

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

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

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

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

APPLICATION: Not applicable.

#99.30 **Disclosure of Claim Files**

The claim file is the master file for recording information used in the adjudication and administration of a claim. Information may exist outside of the claim file. However, all evidence used in the adjudication of the claim is contained in the

claim file. When obtained by the Adjudicator or other Board officer, the opinions of both outside physicians and Board Medical Advisers, as well as any further comments on the part of the Adjudicator or other Board officer, are all recorded on, and become part of, the claim file.

Sensitive personal information that is received, which has not been specifically requested and which is not relevant to the adjudication or administration of the claim will not become part of the claim file. It will normally be destroyed. However, where the original document is still in the Board's possession, it will be returned to the sender when requested by the worker or sender. When the Adjudicator or other Board officer has questions about the relevancy of information received, the information shall be brought to the attention of a Manager. The Manager shall make the decision as to whether information received is sensitive or irrelevant and whether the information should be placed on the claim file.

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

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

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

#99.31 Eligibility for Disclosure

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

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

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

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

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

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

#99.32 Provision of Copies of File Documents

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

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

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

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

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

#99.33 Personal Inspection of Files

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

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

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

Personal inspection of the file will take place in the presence of a Board officer. This officer will explain the general layout of the claim, but will be instructed not to answer enquiries about the contents of file documents. Explanations about what is in the file must be sought from the person or body dealing with the matter, a Workers' Adviser, an Employers' Adviser, or the person's own representative.

#99.34 *Disclosure*

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

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

If it is not a review or appeal situation, a worker may obtain disclosure through the Client Service Manager of the appropriate Service Delivery Location. Where disclosure is available pursuant to the disclosure policies if it is desired simply to inspect the original file in person at an office of the Board outside of the Richmond area, without receiving a copy of the file or after the receipt of a copy, the request may be made directly to the Board office concerned.

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

EFFECTIVE DATE: March 3, 2003

APPLICATION: To disclosures on or after the effective date.

#99.35 *Complaints Regarding File Contents*

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

matter. Where the person making the objection is the worker, anyone who had access to the file in the one-year period prior to the annotation to the record will be informed.

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

#99.40 Tape Recordings of Interviews

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

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

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

#99.50 Disclosure to Public or Private Agencies

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

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

- (e) If the Board determines that compelling circumstances exist which affect the health or safety of an individual.

#99.51 *Legal Matters*

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

At the request of the Board's General Counsel, a Director in the Compensation Services Division may appoint an Adjudicator or other Board officer to be responsible for responding to a subpoena or other request for information from a lawyer.

#99.52 *Other Workers Compensation Boards*

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

#99.53 *Government of Canada*

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

#99.54 *Canada Pension Plan*

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

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

#99.55 Ministry of Social Services

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

#99.56 Police

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

#99.57 Government Employees Compensation Act

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

#99.60 Information to Other Board Departments

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

#99.70 Media Enquiries or Contacts

Unless designated as a media spokesperson, staff at the head office of the Board must refer all media enquiries or contacts to the Community Relations Department. Enquiries received in area offices should be referred to the Area Office Manager.

#99.80 Insurance Companies

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

#99.90 Disclosure for Research or Statistical Purposes

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

- (a) the research purpose cannot reasonably be accomplished unless that information is provided in individually identifiable form or the research purpose has been approved by the Information and Privacy Commissioner.
- (b) any record linkage is not harmful to the individuals that information is about and the benefits to be derived from the record linkage are clearly in the public interest.
- (c) the Board has approved conditions relating to the following:
 - (i) security and confidentiality;
 - (ii) the removal or destruction of individual identifiers at the earliest reasonable times;
 - (iii) the prohibition of any subsequent use or disclosure of that information in individually identifiable form without the express authorization of the Board, and
- (d) the person to whom that information is disclosed has signed an agreement to comply with the approved conditions, the provisions of the *Freedom of Information and Protection of Privacy Act* and any of the Board's policies and procedures relating to the confidentiality of personal information.

#100.00 REIMBURSEMENT OF EXPENSES

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

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

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

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

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

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

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

#100.10 Claimants

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

#100.12 Claims or Review Inquiries

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

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

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

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

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

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

#100.13 Medical Review Panels

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

#100.14 Amount of Expenses

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

to bring more than two witnesses, or intends to bring any witness from a distance of more than twenty-five miles, they should check first by telephone with the Board officer or the review officer, as the case may be.)

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

EFFECTIVE DATE: March 3, 2003 (as to references to the Review Division)

APPLICATION: Not applicable.

#100.40 Fees and Expenses of Lawyers and Other Advocates

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

#100.50 Expenses Incurred in Producing Evidence

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

The cost of medical reports obtained by a worker or employer will also be paid by the Board where, following the claims inquiry or review by the Review Division, it appears reasonable for them or their representative to have assumed, prior to the claims inquiry or review by the Review Division, that the provision of the report was necessary. These costs may be paid even if, after the matter is concluded, it is determined that they had not specifically served to assist in the enquiry.

The Board, in a decision on a claim, refused to pay for medical reports obtained by a worker's lawyer. Although it was a normal and prudent action on the part of a responsible lawyer to seek information in order to acquaint himself properly with his client's problem before pursuing it before the Board, the information contained in the reports could have been obtained from the worker's attending

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

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

EFFECTIVE DATE: March 3, 2003 (as to references to the Review Division)

APPLICATION: Not applicable.

#100.60 Decision on Expenses

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

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

APPLICATION: Not applicable.

#100.70 The Awarding of Costs

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

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

A "contested claim", for the purposes of section 100, is one in respect of which there has been a review by the Review Division by the worker or the employer. An appeal to a Medical Review Panel might amount to a "contest" of a claim but it is unlikely that a question of costs would arise in such a case.

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

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

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

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

EFFECTIVE DATE: March 3, 2003 (as to references to review, the Review Board and section 6 of the *Workers Compensation Act Appeal Regulation*)

APPLICATION: Not applicable.

#100.71 Application for Costs by Dependant

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

“. . . the authority of the Board to enforce payment of an order for costs is limited to an order for payment by an employer, or by a worker. The Third Party in this

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

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

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

#100.72 What Costs May Be Awarded?

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

#100.73 Decisions on Applications for Costs

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

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

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

It may happen that, instead of reaching a specific finding on a matter, the Review Division or the Workers' Compensation Appeal Tribunal will direct that the Compensation Services Division reassess or redetermine something, for example, a permanent partial disability award. The Review Division or the Workers' Compensation Appeal Tribunal finding is properly implemented if the reassessment or redetermination is carried out even if the conclusion reached is the same as the one that was previously reviewed by the Review Division or

appealed to the Workers' Compensation Appeal Tribunal. However, if the Board officer implementing the Review Division or the Workers' Compensation Appeal Tribunal finding is the same one who made the original decision against which the review or appeal was made, and if that person's decision is still negative, the matter is to be referred to a different Board officer for a second look. If a difference of opinion results from the second look, the decision of the second Board officer will prevail.

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

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

EFFECTIVE DATE: March 3, 2003 (this policy item was moved from Chapter 13 and amended to include references to the Review Division or the Workers' Compensation Appeal Tribunal)

APPLICATION: Not applicable.

#100.80 PAYMENT OF CLAIMS PENDING APPEALS

#100.81 Appeals to the Review Division – New Claims

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

When a decision is made to allow a claim that has been protested by an employer, the employer will be advised of the decision and reasons, where possible by telephone, and given an opportunity to provide any additional information. This is similar to the requirement in policy item #99.10 that a worker be advised if the indication on a claim is that it may be disallowed. If the decision remains that the claim should be allowed, payments will be commenced immediately and a letter explaining the decision and reasons will be sent to the employer. The letter will advise the employer of their right to request a review by the Review Division.

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

If the Review Division reverses the decision of the Claims Department to allow the claim, payments are immediately terminated but no attempt is made to recover payment incorrectly made to the worker, unless there was evidence of

fraud or misrepresentation. The employer's sector or rate group will be relieved of the claim costs pursuant to policy item #113.10.

EFFECTIVE DATE: March 3, 2003 (this policy item was moved from Chapter 13 and amended to include references to the Review Division)

APPLICATION: Not applicable.

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

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

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

EFFECTIVE DATE: March 3, 2003 (this policy item was moved from Chapter 13 and amended to include references to the Workers' Compensation Appeal Tribunal)

APPLICATION: Not applicable.

#100.83 Implementation of Review Division Decisions

Section 258 of the *Act* provides as follows:

- (1) If, following a review under section 96.2, a review officer's decision requires payments to be made to a worker or a deceased worker's dependants, the Board must
 - (a) begin any periodic payments, and
 - (b) pay any lump sum due under section 17(13).
- (2) In the absence of fraud or misrepresentation, an amount paid under subsection (1) to a worker or a deceased worker's dependants is not recoverable.
- (3) If a review officer has made a decision described under subsection (1), the Board must defer the payment of any compensation applicable to the time period before that decision
 - (a) for a period of 40 days following the review officer's decision, and

- (b) if the review officer's decision is appealed under section 239, for a further period until the appeal tribunal has made a final decision or the appeal has been withdrawn, as the case may be.
- (4) Subsection (3) applies despite sections 19.1, 22(1), 23(1) or (3), 29(1) or 30(1).
- (5) If the appeal tribunal's decision on an appeal requires the payment of compensation, all or part of which was deferred under subsection (3), interest must be paid on the deferred amount of that compensation as specified in subsection (6).
- (6) Interest payable under subsection (5) must be calculated in accordance with the policies of the board of directors and begins
 - (a) 41 days after the review officer made his or her decision, or
 - (b) on an earlier day determined in accordance with the policies of the board of directors.

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

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

because it is determined that the retroactive benefit was not necessitated by a blatant Board error, interest will be paid beginning 41 days after the date on which the Review Division made its decision. The amount of interest to be paid is to be calculated in accordance with the interest rates set out in policy item #50.00.

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

APPLICATION: Not applicable.

NOTES

- (1) S.53(2)
- (2) S.53(3)
- (3) See policy item #94.11
- (4) *Workers' Compensation Board of British Columbia, W.C.B. News, November – December, 1975, 4*
- (5) S.55(1)
- (6) S.55(1)
- (7) S.12; See policy item #49.00
- (8) S.54(2)
- (9) S.54(3)
- (10) S.54(6)(b)
- (11) S.54(9)
- (12) See policy item #34.40
- (13) See policy item #74.10
- (14) S.56(1)(b)
- (15) S.56(1)(c)
- (16) S.56(5)
- (17) S.56(1)(d)
- ~~(18)~~ **S.99 DELETED**
- (19) See Chapter 16
- (20) See policy item #112.30; policy item #113.30
- (21) See policy item #73.54
- (22) See policy item #34.40
- (23) *Workers' Compensation Board of British Columbia, W.C.B. News Bulletin, September – October, 1973*
- (24) S.5(4); See policy item #14.10
- (25) S.6(3); See policy item #26.21
- (26) S.6(11); See policy item #29.50
- (27) See policy item #95.10
- (28) See policy item #97.10
- (29) See policy item #74.60

- (30) S.88(2)
- (31) S.88(4)
- (32) S.88(5)
- (33) S.21, *Evidence Act*
- ~~(34)~~ ~~S.95(2)~~ **DELETED**
- ~~(35)~~ See policy item #103.00 **DELETED**
- (36) See policy item #48.10

“Minor” severity is expected to cause either no disability or a minor disability.
“Moderate” severity is expected to cause a disability.
“Major” severity is expected to cause serious disability or probable permanent disability.

Percentage

How much disability stems from the compensable injury and how much from the enhancement of the disease, condition or disability and, therefore, to what extent costs should be charged under section 39(1)(e) can never be more than an estimate and will always be difficult to determine.

There may be circumstances where the evidence points to a different percentage being relieved than those suggested in the grid. It is more likely that the grid would be used where the distinction between the effects of the pre-existing disease, condition or disability and the compensable injury are not easily made.

In cases of continuing wage-loss and health care benefits, it may be appropriate for the Board officer to determine that after a particular point in time, all the costs are charged under section 39(1)(e). Alternatively, it may also be determined that a percentage is relieved from a certain time onwards.

A decision on cost relief related to the payment of temporary disability wage loss benefits is distinct and separate from a decision on cost relief for a permanent disability award arising out of the same claim.

No minimum period of temporary disability is required in order for cost relief to be considered on a permanent disability award.

In respect of permanent disability awards, it is necessary for the Disability Awards officer, using his or her own best judgment and having reference to applicable medical evidence, to establish a percentage of cost relief to be granted. It is noted that 100% cost relief cannot be granted for a permanent disability award, as this would imply that no portion of the permanent disability resulted from the work-related injury.

5. Timing of Cost Relief Decisions

Where an employer is eligible for cost relief consideration on a claim, the decision is made at the earliest of:

- a) there being sufficient evidence to make a determination on whether the compensable disability was enhanced by reason of a pre-existing disease, condition or disability; or
- b) the conclusion of temporary disability compensation; or

c) after six months of wage loss has been paid.

Cost relief decisions may be deferred beyond six months of wage loss payment when the impact of the pre-existing disease, condition or disability on the compensable disability is not yet clear, or major diagnostic procedures have been scheduled that would clarify the existence, and/or extent of any pre-existing disease, condition or disability.

6. Communication of Cost Relief Decisions

The Board notifies the eligible employer of all section 39(1)(e) cost relief decisions.

If there is a disagreement with such a decision, the employer may request a review by the Review Division. Unexercised appeal rights on relief of cost decisions made before March 3, 2003 are appealed directly to the WCAT and not to the Review Division.

EFFECTIVE DATE: March 1, 2005

CROSS-REFERENCES: Medical Evidence (policy item #97.30)
Appeal and Review Rights (section 41(1)(a)(i), *Workers Compensation Amendment Act (No. 2), 2002, S.B.C. 2002, c. 66*)

HISTORY: Housekeeping amendment effective April 8, 2005. Combines and replaces policy items #114.40A, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*, #114.40B, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*, #114.43, *Procedure Governing Applications under Section 39(1)(e)*, and #114.50, *Sections 39(1)(d), 39(1)(e) and Federal Government Claims of this Manual*.

Incorporates policy previously set out in Panel of Administrators' Resolution No. 1998/04/23-03 *Re: Section 39(1)(e)*. Section 39(1)(e) cost relief consideration does not occur on claims where wage loss ended and/or a permanent disability award was established on or before December 31, 1993. On or after July 1, 1998, section 39(1)(e) cost relief consideration is available for claims in which the pre-existing disease, condition or disability arises from an earlier compensable injury or disease with the same employer as the compensable injury or disease for which relief is sought.

	Percentage
23. Toes, great	2.5
• with head of metatarsal	5
24. Toes, great at distal	1
25. Toes, other than great, each	.5
• metatarsal, each	.5
26. Toe, little with metatarsal	2

LOWER EXTREMITY IMMOBILITY

(B) Immobility:

27. Hip	30
(a) Flexion	9
(b) Extension	2
(c) Abduction	7
(d) Adduction	3
(e) External Rotation	6
(f) Internal Rotation	3
28. Knee	25
29. Ankle	12
30. Great toe, MP Joint	1.25
31. Great toe, distal	.5
32. (a) Talocalcaneal arthrodesis, up to	4.25
(b) Triple arthrodesis	7.0

(C) Shortening:

33. (a) 1.5 cm or less	0
(b) 1.6 cm to 2.5 cm	2
(c) 2.6 cm to 3.5 cm	3
(d) 3.6 cm to 4.5 cm	4
(e) 4.6 cm to 5.5 cm	6
(f) 5.6 cm to 6.5 cm	8
(g) 6.6 cm to 7.4 cm	10
(h) 7.5 cm or more	15

	Percentage
(D) Ligamentous Laxity	
34. Ligamentous Laxity of Knee	
(a) ACL or PCL	
Grade I/Mild (5 – 9 mm)	1.67
Grade II/Moderate (10 – 14 mm)	3.34
Grade III/Marked (15 mm or more)	5
(b) MCL or LCL	
Grade I/Mild (5 – 9 mm)	0.83
Grade II/Moderate (10 – 14 mm)	1.66
Grade III/Marked (15 mm or more)	2.5
35. Ligamentous Laxity of Ankle	
Medial or Lateral	0-2
(E) Miscellaneous Surgical Procedures	
36. Total Hip Prosthesis	6
37. Total Knee Prosthesis or Hemiarthroplasty	9

(F) Lower Extremity Normal Range of Motion Values

	Degrees
HIP	
Flexion	113
Extension	28
Abduction	48
Adduction	31
Internal Rotation	30
External Rotation	45

	Degrees
KNEE	
Flexion	134
Extension	0
ANKLE	
Dorsiflexion	18
Plantar Flexion	40
SUBTALAR	
Inversion	5
Eversion	5
GREAT TOE	
IPJ Flexion	60
Extension	0
MPJ Flexion (Plantar Flexion)	37
Extension (Dorsi Flexion)	63

DENERVATION

	Percentage
38. Median nerve complete at elbow	40
Median nerve complete at wrist	20
39. Ulnar nerve complete at elbow	10
Ulnar nerve complete at wrist	8
40. Peroneal, complete	10
41. Femoral nerve	12.5

IMPAIRMENT OF VISION

42. Enucleation	18
43. Industrially blind, single eye	16
44. Cataract or aphakia	12
45. Double aphakia	20

	Percentage
46. Hemianopia, right or left field	25
47. Diplopia, all fields	10
48. Scotomata, depending on location and extent	Up to 16

Loss of Visual Acuity:

49. 20/30	0
50. 20/40	1
51. 20/50	2
52. 20/60	4
53. 20/80	6
54. 20/100	8
55. 20/200 or poorer	16

IMPAIRMENT OF HEARING

Unilateral Hearing Loss:

56. Difference of 20 dB average at 500 cps, 1000 cps and 2000 cps	1
57. Difference of 30 dB average at 500 cps, 1000 cps and 2000 cps	2
58. Difference of 40 dB average at 500 cps, 1000 cps and 2000 cps	3

Bilateral Hearing Loss:

59. 35 dB ANSI (25 ASA) in single ear	0.2
60. 40 dB ANSI (30 ASA) in single ear	0.3
61. 45 dB ANSI (35 ASA) in single ear	0.5
62. 50 dB ANSI (40 ASA) in single ear	0.7

Percentage

63.	55 dB ANSI (45 ASA) in single ear	1.0
64.	60 dB ANSI (50 ASA) in single ear	1.3
65.	65 dB ANSI (55 ASA) in single ear	1.7
66.	70 dB ANSI (60 ASA) in single ear	2.1
67.	75 dB ANSI (65 ASA) in single ear	2.6
68.	80 dB ANSI (70 ASA) in single ear	3.0

SCHEDULE D

NON-TRAUMATIC HEARING LOSS (SECTION 7)

	Percentage
69. Complete loss of hearing in both ears	15.0
70. Complete loss of hearing in one ear with no loss in the other	3.0

Loss of hearing in dbs measured in each ear in turn (ANSI)	Percentage of total disability Ear most affected PLUS ear least affected	
0 - 27	0	0
28 - 32	0.3	1.2
33 - 37	0.5	2.0
38 - 42	0.7	2.8
43 - 47	1.0	4.0
48 - 52	1.3	5.2
53 - 57	1.7	6.8
58 - 62	2.1	8.4
63 - 67	2.6	10.4
68 or more	3.0	12.0

	Percentage
71. Loss of Kidney	15
72. Loss of Spleen	10

THE SPINE

(CODIFIED MARCH 1, 1990)

This Schedule recognizes that anatomical loss or damage resulting from injury or surgery may contribute to physical impairment of the spine. When anatomic and/or surgical impairment is present as well as loss of range of movement of the spine, the final disability rating will be based on the greater of the two.

Range of movement of the spine is difficult to assess on a consistent basis because the joints of the spine are small, inaccessible and not externally visible. Only movement of a region of the spine can be measured; it is not possible to measure mobility of a single vertebra. Spine movement also varies with an individual's body type, age and general health. Because of these, a judgment factor will continue to be necessary in spine assessment.

Cervical Spine:

	Percentage
73. (a) Compression fractures	
(i) Up to 50% compression	0-2% impaired
(ii) Greater than 50% compression	2-4% impaired
(b) Impairment resulting from surgical loss of intervertebral disc C1 to D1	2% per level
(c) Ankylosis (fusion) C1 to D1 including surgical loss of intervertebral disc	3% per level
74. Loss of range of motion	
Flexion	0-6%
Extension	0-3%
Lateral flexion right and left	each 0-2%
Rotation right and left	each 0-4%
Maximum disability rating not to exceed	21%

Percentage

Thoracic Spine:

75. (a) Compression fractures
- (i) Up to 50% compression 0-1% impaired
 - (ii) Over 50% compression 1-2% impaired
- (b) Impairment resulting from surgical loss of intervertebral disc D1 to D12 1% per level to a maximum of 6%
- (c) Ankylosis (fusion) D1 to D12 including surgical loss of intervertebral disc 1% per level to a maximum of 6%
- (d) Loss of Range of Motion Rotation, Right and Left, Each 0-3%
- Maximum disability rating not to exceed 6%

Lumbar Spine:

76. (a) Compression fractures to include D12
- (i) Up to 50% compression 0-2%
 - (ii) Over 50% compression 2-4%
- (b) Impairment resulting from surgical loss of intervertebral disc D12 to S1 2% per level
- (c) Ankylosis (fusion) D12 to S1 including surgical loss of intervertebral disc 4% per level
77. Loss of range of motion
- Flexion 0-9%
 - Extension 0-5%
 - Lateral flexion right and left each 0-5%
- Maximum disability rating not to exceed 24%

Spine Normal Range of Motion Values

Degrees

CERVICAL SPINE

Flexion	40
Extension	40
Lateral Flexion	30
Rotation	60

THORACIC SPINE

Rotation	45
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LUMBAR SPINE

Flexion	60
Extension	25
Lateral Flexion	25

Psychological Disability

78.	Aphasia and Communication Disturbances	%
(a)	Mild - minimal disturbance in comprehension and production of language symbols of daily living	0-25
(b)	Moderate - moderate disturbance in comprehension and production of language symbols of daily living	30-70
(c)	Marked - inability to comprehend language symbols. Production of unintelligible or inappropriate language for daily activities	75-95
(d)	Extreme - complete inability to communicate or comprehend language symbols	100

79.	Disturbances of Mental Status and Integrative Functioning	%
(a)	Mild - some impairment but ability remains to satisfactorily perform most activities of daily living	0-25
(b)	Moderate - impairment necessitates direction and supervision of daily living activities	30-70
(c)	Marked - impairment necessitates directed care under continued supervision and confinement in home or other facility	75-95
(d)	Extreme - individual is unable without supervision to care for self and be safe in any situation	100
80.	Emotional (Mental) and Behavioural Disturbances	
	The impairment levels below relate to activities of daily living, social functioning, concentration, and adaptation	
(a)	Mild - impairment levels are compatible with most useful functioning	0-25
(b)	Moderate - impairment levels are compatible with some, but not all useful functioning	30-70
(c)	Marked - impairment levels significantly impede useful functioning	75-95
(d)	Extreme - impairment levels preclude most useful functioning	100

Disability ratings greater than 0% are made in 5% increments.

EFFECTIVE DATE: August 1, 2003
APPLICATION: To all section 23(1) assessments and reassessments undertaken with reference to the *Permanent Disability Evaluation Schedule* on or after August 1, 2003.