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WORKING TO MAKE A DIFFERENCE

BOARD OF DIRECTORS
Douglas J. Enns, Chair
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Roslyn Kunin
Robert Smith

2007/07/17-09

THE WORKERS' COMPENSATION BOARD OF BRITISH COLUMBIA

RESOLUTION OF THE BOARD OF DIRECTORS

RE: Miscellaneous Amendments – Claims Management Solutions ("CMS")

WHEREAS:

Pursuant to section 82 of the *Workers Compensation Act,* RSBC 1996, Chapter 492 and amendments thereto ("*Act*"), 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;

AND WHEREAS:

The clothing allowance amounts set out in policy item #79.00 of the *Rehabilitation Services & Claims Manual*, Volumes I and II ("*RS&CM*") are adjusted on July 1st each year, while all other dollar amounts in the *Act* and policy are adjusted on January 1st of each year;

AND WHEREAS:

A number of minor policy changes have been identified as part of the CMS development which will improve the overall functionality of the CMS system.

THE BOARD OF DIRECTORS RESOLVES THAT:

1. Amendments to policy items #26.04, #32.50, #48.41, #74.21, #77.30, and #79.00 of the *RS&CM*, Volume I and policy items #26.04, #32.50, #48.41, #74.21, #79.00, #96.20 and #96.30 of the *RS&CM*, Volume II, attached to this Resolution, are approved and apply on or after October 1, 2007.

2. This resolution is effective October 1, 2007.

3. This resolution constitutes a policy decision of the Board of Directors.

DATED at Richmond, British Columbia, July 17, 2007.

By the Workers' Compensation Board

ROSLYN KUNIN, VICE-CHAIR
BOARD OF DIRECTORS

APPENDIX A

REHABILITATION SERVICES & CLAIMS MANUAL
DRAFT VOLUME I POLICY

Additions In Bold And Deletions Struckthrough

#26.04 Recognition by Order Dealing with a Specific Case

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

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

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

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

If, however, after seeking such input from the worker and employer, the Adjudicator concludes that the facts do not warrant recognition of the worker's condition as an occupational disease, the Adjudicator will disallow the claim without referring it to the panel, and will notify the worker and employer. This is a

reviewable decision. The Adjudicator shall ~~provide~~**advise** the Manager ~~with a memorandum advising~~ that the worker's condition is not one previously designated or recognized by the Board as an occupational disease, the nature of the condition, and the Adjudicator's decision to disallow the claim.

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

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

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

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

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

EFFECTIVE DATE: ~~March 3, 2003 (as to references to review)~~ **October 1, 2007 – Revised to delete references to memos and memorandums.**

APPENDIX A

REHABILITATION SERVICES & CLAIMS MANUAL
DRAFT VOLUME I POLICY

Additions In Bold And Deletions Struckthrough

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

APPLICATION: ~~Not applicable~~ **Applies on or after October 1, 2007**

APPENDIX A

REHABILITATION SERVICES & CLAIMS MANUAL
DRAFT VOLUME I POLICY

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#32.50 "Date of Injury" for Occupational Disease

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

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

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

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

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REHABILITATION SERVICES & CLAIMS MANUAL
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#48.41 When Does an Overpayment of Compensation Occur?

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

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

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

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

EFFECTIVE DATE:	~~March 3, 2003 (as to deletion of cross-references to payments to children on fatal claims, interim adjudications and appeals)~~ **October 1, 2007 – Revised to remove reference to computer errors.**
HISTORY	**March 3, 2003 (as to deletion of cross-references to payments to children on fatal claims, interim adjudications and appeals)**
APPLICATION:	~~Not applicable.~~**Applies on or after October 1, 2007**

APPENDIX A

REHABILITATION SERVICES & CLAIMS MANUAL
DRAFT VOLUME I POLICY

Additions In Bold And Deletions Struckthrough

#74.21 Duration of Treatment

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

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

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

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

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

this should be denied unless it is too frequent" or "I have no objection to chiropractic treatment if the worker thinks it is going to help."

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

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

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

EFFECTIVE DATE: ~~March 3, 2003 (as to references to review)~~ **October 1, 2007 – Revised to delete references to memos and memorandums.**

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

APPLICATION: ~~Not applicable~~ **Applies on or after October 1, 2007**

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#77.30 THE PRESCRIPTION OF NARCOTICS AND OTHER DRUGS OF ADDICTION

The following policy applies:

1. Board responsibility for narcotic analgesics, hypnotic-sedatives and tranquilizers (see examples in Table 1) will be limited to a post-injury or post-surgery period of eight weeks. An extension of this eight-week period may be considered, however, where there are special or extenuating circumstances; for example, where a worker has received, or will receive, a permanent disability pension and requires regular intermittent and limited narcotic preparation for the relief of pain.

2. If an Adjudicator or Payment Clerk continue to receive accounts for these drugs beyond the eight-week limit, the worker's claim file will be referred by the Adjudicator to a Board Medical Advisor. The Board Medical Advisor will contact the attending physician by phone where possible, outline the details of this policy, and discuss any special or extenuating circumstances. The Board Medical Advisor will also discuss the use of acceptable therapeutic alternatives such as: N.S.A.I.D.'s, anti-depressives, T.N.S., biofeedback. If necessary, an extension beyond eight weeks may be recommended by the Board Medical Advisor following this discussion.

3. The Board Medical Advisor's discussion and resulting recommendation will then be documented ~~in a memo~~ on the worker's claim file and referred to the Adjudicator.

4. The Adjudicator's decision will be communicated in writing to the worker with a copy to the attending physician.

Table 1

1. **Analgesic Target Drugs**

    a. Analgesic combinations containing 50 mg or more of Codeine

    b. Pentazocine and combinations (Talwin®, Talwin Compound 50®)

    c. Oxycodone and combinations (Percodan®, Percocet®, etc.)

    d. Propoxyphene and combinations (Darvon N®, 642®, 692®, etc.)

e. Merperidine (oral) (Demerol®)

f. Barbiturate + A.S.A. + Codeine combinations (Fiorinal®, Anadol®, Phenaphen®)

g. Anileridine (Leritine)

h. Morphine and M.S. Contin and M.O.S.

i. Hydromorphone (Dilaudid)

2. **Sedative-Hypnotic Drugs**

   a. Barbiturates

   b. Meprobamate

3. **Tranquilizers**

   a. Diazepam

   b. Chlordiazepoxide

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

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

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#79.00 CLOTHING ALLOWANCES

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

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

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

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

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

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

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

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

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

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

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REHABILITATION SERVICES & CLAIMS MANUAL
DRAFT VOLUME II POLICY

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#26.04 Recognition by Order Dealing with a Specific Case

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

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

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

A Board officer upon investigating an individual claim may find that the condition suffered by the worker is not one listed in the first column of Schedule B, nor is it one which has been previously designated or recognized by the Board as an occupational disease under section 6(4.2). If the Board officer concludes, after seeking appropriate input from both the worker (or their legal representative) and the employer (if a specific employer is identified) that the facts warrant recognition of the worker's condition as an occupational disease, the Board officer will refer the claim with a recommendation to that effect to a panel made up of his or her Client Services Manager, (referred to in this section as the "Manager", and a Board Medical Advisor (referred to in this section as the "Medical Advisor").

If, however, after seeking such input from the worker and employer, the Board officer concludes that the facts do not warrant recognition of the worker’s condition as an occupational disease, the Board officer will disallow the claim without referring it to the panel, and will notify the worker and employer. This is a reviewable decision. The Board officer shall ~~provide~~**advise** the Manager ~~with a~~

~~memorandum advising~~ that the worker's condition is not one previously designated or recognized by the Board as an occupational disease, the nature of the condition, and the Board officer's decision to disallow the claim.

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

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

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

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

The designation or recognition of an occupational disease by inclusion in Schedule B, under section 6(4.2), where a particular process, trade or occupation is specified, or by regulation of general application, does not preclude its recognition by order dealing with a specific case if it occurred prior to its designation or recognition by one of the other alternate methods.

EFFECTIVE DATE: ~~March 3, 2003 (as to references to review)~~ **October 1, 2007 – Revised to delete references to memos and memorandums.**

APPENDIX A

REHABILITATION SERVICES & CLAIMS MANUAL
DRAFT VOLUME II POLICY

Additions In Bold And Deletions Struckthrough

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

APPLICATION: ~~Not applicable~~ **Applies on or after October 1, 2007**

APPENDIX A

REHABILITATION SERVICES & CLAIMS MANUAL
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#32.50 "Date of Injury" for Occupational Disease

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

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

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

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

APPENDIX A

REHABILITATION SERVICES & CLAIMS MANUAL
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#48.41 When Does an Overpayment of Compensation Occur?

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

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

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

EFFECTIVE DATE: ~~March 3, 2003 (as to deletion of cross-references to payments to children on fatal claims, interim adjudications and appeals)~~ **October 1, 2007 – Revised to remove reference to computer errors.**

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

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

APPENDIX A

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#71.40 Adjustments

The Board may adjust a worker's average ~~net~~ earnings **subject to reconsideration rules set out in section 96(5) of the *Act***, 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~~**may** be made.

EFFECTIVE DATE: **October 1, 2007 – Revised to include reference to section 96(5) of the *Act* and to delete the term net.**

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

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REHABILITATION SERVICES & CLAIMS MANUAL
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#74.21 Duration of Treatment

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

1. Have the worker examined at the Board.
2. Refer the worker for an orthopaedic or other appropriate specialist consultation.
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Giving preference to an examination by a Board Medical Advisor is simply an effective method of determining whether options 2 or 3 are necessary or appropriate, or whether some other approach or decision is indicated.

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

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

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

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

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

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

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#79.00 CLOTHING ALLOWANCES

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

The amounts of the clothing allowances are set out below:

	Single Upper Limb Amputee	Bilateral Upper Limb Amputee	Lower Limb Amputee or Requires a Leg Brace	Upper and Lower Limb Amputee
July 1, 2005 - June 30, 2006	$277.57	$556.50	$556.50	$834.15
July 1, 2006 - June 30, 2007	$284.35	$570.09	$570.09	$854.53

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

~~Effective June 30, 2002, the amounts of the clothing allowances will be adjusted on July 1 of each year. The Board determines the percentage change to be applied annually to these amounts by comparing the percentage change in the consumer price index for April of the current year to April of the previous year~~.

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

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

Entitlement to this allowance commences as of the date of the amputation or the worker's commencing to use the brace or wheelchair. Payment is made by separate cheque on ~~July~~**January 1st** of each year. This is a full calendar year

payment and covers ~~the~~ ~~prior six months and the following six months in~~ the year of payment. The first payment is made on the ~~July~~**January 1st** following the initiation of pension payments and this first payment will include any retroactive entitlement for prior periods of disability not **previously paid**~~covered by this first annual payment~~.

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

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

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

APPENDIX A

REHABILITATION SERVICES & CLAIMS MANUAL
DRAFT VOLUME II POLICY

Additions In Bold And Deletions Struckthrough

#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,~~ **the claim file will** clearly ~~setting out~~**indicate** 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~~ **October 1, 2007 – Revised to delete references to memos and memorandums.**

APPENDIX A

REHABILITATION SERVICES & CLAIMS MANUAL
DRAFT VOLUME II POLICY

Additions In Bold And Deletions Struckthrough

HISTORY:	**July 2, 2004 – Revisions to the role of Board officers and removal of criterion on a worker's self-referral to Disability Awards applied to all decisions, including appellate decisions, made on or after July 2, 2004.**
APPLICATION:	~~Applies to all decisions, including appellate decisions, made on or after July 2, 2004.~~ **Applies on or after October 1, 2007**

APPENDIX A

REHABILITATION SERVICES & CLAIMS MANUAL DRAFT VOLUME II POLICY

Additions In Bold And Deletions Struckthrough

#96.30 Board Officers in Disability Awards

Where the Board officer has accepted an actual or potential permanent disability, Board officers in Disability Awards then decide the extent of the disability and calculate the worker's permanent disability award entitlement. Board officers in Disability Awards must accept the final decision of the Board officer as to what conditions are accepted under the claim. ~~The Board officer is required to outline the decision in a memo when referring the claim to the Disability Awards Department.~~

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

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

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

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

The final decision on the assessment of a permanent disability award under section 23(3) is made by the Disability Awards Committee which consists of one senior representative from the Disability Awards, Medical, and Vocational Rehabilitation Services Departments.

Requests for the commutation of permanent disability awards are adjudicated in the first instance by Board officers in Disability Awards. Before making a decision, they may ask the Vocational Rehabilitation Consultant to contact the worker and obtain the necessary information.

EFFECTIVE DATE: ~~July 2, 2004~~ **October 1, 2007 – Revised to delete references to memos and memorandums.**

HISTORY: **July 2, 2004 – Revisions to the role of Board officers applied to all decisions, including appellate decisions, made on or after July 2, 2004.**

APPENDIX A

REHABILITATION SERVICES & CLAIMS MANUAL
DRAFT VOLUME II POLICY

Additions In Bold And Deletions Struckthrough

APPLICATION: ~~Applies to all decisions, including appellate decisions, made on or after July 2, 2004.~~ **Applies on or after October 1, 2007**