

Additions in Bold; Deletions Strikethrough

VOLUME II

CHAPTER 12

CLAIMS PROCEDURES

#92.00 INTRODUCTION

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

#93.00 RESPONSIBILITIES OF CLAIMANTS

#93.11 Procedure for Reporting

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

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

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

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

Many employers set up their own system of reporting to assist them in carrying out their obligations. If the worker, however, reports to some other company

official who was not designated by the employer, this does not mean there is no compliance with his or her responsibilities under the ~~Act~~ **Act**.

~~#93.13 — Injuries, Disablements, or Deaths
— Occurring Prior to August 1, 1974~~

~~The provisions discussed in #93.10-12 apply to injuries, disablements from occupational disease and deaths occurring on or after August 1, 1974. Similar rules operated in respect of injuries, disablements and deaths occurring prior to that date, although the wording of the statutory provisions is different. (5)~~

#93.20 Application for Compensation

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

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

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

#93.21 Time Allowed for Submission of Application

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

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

The section is not complied with simply by reporting the injury to the first aid attendant or having it confirmed by witnesses. The one-year period commences at the date of injury or death, and except in the case of occupational diseases,

not at the date of subsequent disablement. In the case of occupational diseases, reference should be made to **policy item #32.50**.

#93.22 *Application Made Out of Time*

Before an application for compensation can be considered on its merits, it must satisfy the requirements of Section 55. It is important to distinguish between the decision on the merits of the claim and the decision made under Section 55, since the distinction may affect the rights of appeal which a person has to challenge the decision. In particular, while a decision on the merits may be appealable to a Medical Review Panel, a decision that Section 55 bars or does not bar a claimant's application from being considered cannot be appealed to that body. Therefore, even though a Claims Adjudicator may feel that a claim will, in any event, be denied on the merits, he or she must always first reach a separate decision on the effect of Section 55.

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

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

- (3.1) The board may pay the compensation provided by this Part for the period commencing on the date the board received the application for compensation if
 - (a) the board is satisfied that special circumstances existed which precluded the filing of an application within one year after the date referred to in subsection (2), and
 - (b) the application is filed more than 3 years after the date referred to in subsection (2).

- (3.2) The board may pay the compensation provided by this Part if
 - (a) the application arises from death or disablement due to an occupational disease,
 - (b) sufficient medical or scientific evidence was not available on the date referred to in subsection (2) for the board to recognize the disease as an occupational disease and this evidence became available on a later date, and

- (c) the application is filed within 3 years after the date sufficient medical or scientific evidence as determined by the board became available to the board.

(3.3) The board may apply subsection (3.2) to an application in respect of a death or disablement from an occupational disease that the board previously considered since July 1, 1974 under the equivalent to this section."

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

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

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

1. Special Circumstances

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

The following facts illustrate a situation where special circumstances were found to exist. The claimant suffered a minor right wrist injury on October 20, 1976, which at the time caused him no disablement from work and did not require him to seek medical attention. There was, therefore, no reason why he should claim compensation from the

Board, nor any reason why his doctor or employer should submit reports to the Board. It was not until 1978 when the claimant began to experience problems with his right wrist that he submitted a claim to the Board. It was only then that he was incurring monetary losses for which compensation might be appropriate.

2. Discretion of the Board

Assuming the Board accepts that there were special circumstances that precluded the claimant from submitting an application within the one-year period, the second requirement of Section 55(3) must then be dealt with. The question arises as to whether or not the Board should exercise its discretion to pay compensation.

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

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

The facts of the case discussed above illustrate a situation where, even though there were special circumstances precluding the claimant from submitting his application within the one-year period, the Board decided to exercise its discretion against allowing the claimant's application to be considered on its merits. The fact that the initial injury was a minor one which caused no immediate problems and required no medical treatment meant that it was impossible

to obtain detailed evidence as to the real nature of the original injury. Furthermore, this was a case where detailed medical evidence of this nature would be particularly necessary since, on the face of it, it would be hard to relate the claimant's complaints to such a minor injury two years before.

The exercise of the Board's discretion under Section 55(3) may, in some cases, appear in substance to be closely related to the question that would arise on the merits of the claim as to whether the injury in question occurred and whether it caused the claimant's subsequent complaints. If there is now an inability to obtain evidence regarding the original injury, that would normally mean that the claim would be disallowed on the merits for lack of evidence to support it. On the other hand, there will be cases where, notwithstanding the Board's exercising its discretion in favour of allowing an application to be considered, the claim will nevertheless be disallowed on the merits. For the reason connected with the appeals system outlined at the beginning of **policy item** #93.22 it is always necessary, in any event, to separate the decision on the merits and the exercise of discretion under Section 55(3).

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

#93.23 *Adjudication without an Application*

Where the Board is satisfied that compensation is payable, it may be paid without an application. (7 5)

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

1. The employer is objecting to the claim.
2. The claim is doubtful.
3. A disability award may result.
4. In personal optional protection cases before wage loss is payable.

5. Before an interim adjudication under **policy item #96.21** is carried out.
6. In third-party and out-of-province cases.
7. Silicosis claims.
8. On fatal claims before a pension can be paid. A decision on the acceptability of the claim and the payment of funeral and lump-sum benefits can be made without an application.

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

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

~~#93.24 — Injuries, Occupational Diseases, and Deaths
— Occurring Prior to January 1, 1974~~

~~The provisions set out in subsections 55(1) to and including 55(3.3) apply to an injury or death occurring on or after January 1, 1974, and to an occupational disease in respect of which exposure to the cause of the occupational disease in the province did not terminate prior to that date. (8)~~

~~In respect of injuries, deaths and disablements by occupational diseases occurring prior to that date, the predecessor of the *Workers' Compensation Act*, 1968, C.59, S. 52, provided as follows:~~

- ~~"(1) Unless an application for compensation is filed~~
- ~~(a) within one year after the day upon which the injury or disablement by industrial disease occurred; or~~
- ~~(b) in case the applicant is a dependent, within one year after the death,~~
- ~~no compensation other than medical aid is payable under this Part.~~
- ~~(2) Medical aid is payable if proof of injury is filed within one year of the occurrence of injury or disablement from industrial disease without a formal application therefor being filed by the workman.~~
- ~~(3) The application for compensation shall be made on the form~~

~~_____ prescribed by the Board or the regulations and shall be signed
by
_____ the workman or dependent.~~

~~(4) _____ Where the Board is satisfied that there existed special
_____ circumstances which precluded the filing of an application within
_____ the period set out in subsection (1), it may pay the compensation
_____ provided by this Part on receipt of proof of injury and an
application filed by the workman within three years from the date of injury or one
year from the date of commencement of the first period of temporary partial or
temporary total disablement from an industrial disease, or by a dependant within
three years after the death." (9)~~

~~The effect of Subsection (4) is that no compensation is payable under any
circumstances where the application for compensation was, in the case of
personal injury, received more than three years after the date of injury and, in
the case of occupational disease, received more than one year after the first
disablement from work. The Board has no general power to waive these
requirements and extend the time period in which an application must be
submitted beyond the period set out in Section 52(4).~~

~~For the application of this section to hearing-loss claims where the exposure to
industrial noise terminated prior to January 1, 1974, reference should be made
to #31.70.~~

#93.25 *Signature on an Application for Compensation*

The application for compensation must be signed by the worker. ~~(4)~~ **(6)** Printed signatures are not acceptable, except in the case of claimants whose education has been in a different script, for example, claimants of East Indian or Chinese origin. A carbon copy of a signature is not acceptable.

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

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

Unless otherwise disabled, a worker under the age of 19 years can and should sign the application form. ~~(4)~~ **(7)**

#93.30 Medical Treatment and Examination

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

#93.40 Working While Receiving Wage-Loss Benefits

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

#94.00 RESPONSIBILITIES OF EMPLOYERS

#94.10 Report to the Board

Subject to **policy item #94.12-13**, an employer shall report to the Board within three days of its occurrence every injury to a worker that is or is claimed to be one arising out of and in the course of employment.

Subject to **policy item #94.12-13**, an employer shall report to the Board within three days of receiving information under Section 53, (~~42~~ **8**) every disabling occupational disease, or claim for or allegation of an occupational disease.

An employer shall report immediately to the Board and to its local representative the death of a worker where the death is or is claimed to be one arising out of and in the course of employment. (~~13~~ **9**)

The application of the above provisions to claims by commercial fishers is discussed in Fishing Industry Regulations 10 and 4 (found in Workers' Compensation Reporter Decisions 223 and 224).

#94.11 Form of Report

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

1. the name and address of the worker;
2. the time and place of the disease, injury, or death;
3. the nature of the injury or alleged injury;
4. the name and address of any physician or qualified practitioner who attended the worker; and

5. any other particulars required by the Board or by the regulations, and may be made by mailing copies of the form addressed to the Board at the address the Board prescribes.

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

- | | |
|---------|---|
| Form 7 | Employer's Report of Injury or Occupational disease |
| Form 7A | First Aid Report (Supplementary to Employer's Form 7. It is completed by the first aid attendant, or other person rendering first aid.) |
| Form 9 | Employer's Subsequent Statement (Completed at the employer's option or at the Board's request, as soon as the injured worker has returned, or is able to work.) |

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

#94.13 Commencement of the Obligation to Report

The obligation of the employer to report the injury to the Board commences when a supervisor, first aid attendant, or other representative of the employer first becomes aware of any one of the conditions listed in **policy item #94.12**, or when notification of any such condition is received by mail or telephone at the local or head office of the employer. (~~44~~ **10**)

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

#94.14 *Adjudication and Payment without Employers Report*

An employer is always given an adequate opportunity to submit a ~~F7~~ **Form 7** employer's report before a claim is adjudicated in its absence. If a claim is adjudicated without a Form 7 employer's report and then, after adjudication to allow and pay the claim, the employer's report is received objecting to the acceptability of the claim, the Claims Adjudicator will investigate any of the matters raised in the objection. If, following investigation the Claims Adjudicator is satisfied that the claim was properly accepted, the employer will be advised of the details and informed of the rights of appeal. Payments to the worker will be continued during the investigation unless there is evidence suggesting fraud. In this case, the procedure set out in **policy item #96.23** may be followed. If following an investigation an Claims Adjudicator is satisfied that on the basis of

the new evidence the claim should not have been accepted, permission to re-adjudicate is requested in accordance with **policy item #108.30**.

#94.15 *Penalties for Failure to Report*

Section 54(5) provides that “The failure to make a report required by virtue of this section, unless excused by the board on the ground that the report for some sufficient reason could not have been made, constitutes an offence against this Part.” The maximum fine for committing this offence is set out in Part 1 of Appendix 6.

Section 54(7) provides that “Where a report required by this section is not received by the board within 7 days of an injury or death, or any other time prescribed by regulation under . . .” **policy item #94.13**, “. . . the board may make an interim adjudication of the claim, and, where it allows the claim on an interim basis, may commence the payment of compensation in whole or in part.”

Section 54(8) provides that “Any compensation paid under subsection (7), until 3 days after receipt by the board of the report required by this section, may be levied and collected from the employer by way of additional assessment . . ., and payment may be enforced in like manner as other assessments.”

Where the Board is satisfied that the delay in reporting was excusable, it may relieve the employer in whole or in part of the additional assessment imposed under Subsection (8). (15 11)

Effective January 1, 1978, the Board established a procedure for implementing Section 54(7)-(8).

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

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

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

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

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

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

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

When the Form 7 employer's report does arrive, it can be considered as evidence in making the final adjudication of the claim. The readjudication procedures set out in **policy item #108.30** do not have to be followed if the decision is that the claim should be disallowed. The rules set out in **policy item #96.21** regarding the non-recovery of payments made under an interim adjudication also apply here. If the employer's report protests the acceptance of the claim, but the final adjudication is that it remain allowed, the employer will receive the usual notification of the right of appeal.

The above procedure applies to pay employer claims (16 12) and to employers with deposit accounts, but not to personal optional protection or Federal Government claims.

#94.20 Employer or Supervisor Must Not Attempt to Prevent Reporting

Section 177 of the ~~Workers Compensation Act~~ **Act** provides as follows:

An employer or supervisor must not, by agreement, threat, promise, inducement, persuasion or any other means, seek to discourage, impede or dissuade a worker of the employer, or a dependant of the worker, from reporting to the board

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

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

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

As an alternative to imposing an administrative penalty, the Board may refer the case to Crown Counsel for consideration of prosecution. The maximum fine that may be levied following conviction is set out in Part 2 of Appendix 6.

#95.00 RESPONSIBILITIES OF PHYSICIANS/QUALIFIED PRACTITIONERS

It is the duty of every physician or qualified practitioner (~~47~~ **13**) attending or consulted on a case of injury to a worker, or alleged case of injury to a worker, in any industry within the scope of Part 1 of the ~~Act~~ **Act** to furnish reports in respect of the injury in the form required by the regulations or by the Board.

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

If treatment continues, progress reports must be provided.

The physician or qualified practitioner must furnish a report within three days after the worker is, in the opinion of the physician or qualified practitioner, able to resume work and, if treatment is being continued after resumption of work, furnish further adequate reports. (~~18~~ **14**)

#95.10 Form of Reports

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

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

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

All medical reports must be signed by the person making the report. A rubber stamp should also be used to denote the professional designation of a partnership or a clinic. The original report, not the carbon copy, should be mailed to the Board. Any change in status of a partnership or clinic, or change in its address, should be reported in writing to the Board without delay to assure proper direction of payment.

#95.20 Reports by Specialist

If the physician is a specialist whose opinion is requested by the attending physician, the worker, or the Board, or if he or she continues to treat the worker after being consulted as a specialist, a first report must be furnished to the Board within three days after completion of the consultation; but if the specialist is

regularly treating the worker, the specialist shall submit reports as required in **policy item #95.00. (49 15)**

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

#95.30 Failure to Report

Physicians, qualified practitioners, or other persons who fail to submit prompt, adequate and accurate reports and accounts as required by the ~~Act~~ **Act** or the Board commit an offence, and their right to be selected by a worker to render health care may be cancelled by the Board, or they may be suspended for a period to be determined by the Board. When the right of a person to render health care is so cancelled or suspended, the Board shall notify the person of the cancellation or suspension, and shall likewise inform the governing body named in the ~~Act~~ **Act** under which the person is authorized to treat human ailments, and the person whose right to render health care is cancelled or suspended shall also notify any injured workers who seek treatment from him or her of the cancellation or suspension. (20 16)

The maximum fine for the offence committed under the ~~Act~~ **Act** is set out in Part 1 of Appendix 6.

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

#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. (24 17)

#96.00 THE ADJUDICATION OF COMPENSATION CLAIMS

Section 96(1) of the ~~Act~~ **Act** provides that “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 must not be maintained or brought against a governor, officer, appeal commissioner or employee of the board in respect of an act, omission or decision done or made in the belief that it 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.”

#96.10 Precedent and Policy

Section 82 provides that the Governors shall approve and superintend the policies of the Board. This means that the Governors are required to set the policies of the Board. While Board officers, the review board, the Appeal Division, and Medical Review Panels may make decisions in individual cases, only the Governors have the responsibility and authority to set the policies of the Board.

Decision #3 of the Governors provides as follows:

The published policies of the Governors as of June 3, 1991, consist of the following:

1. Assessment Policy Manual

2. Occupational Safety and Health Division Policy and Procedure Manual
3. Rehabilitation Services & Claims Manual
4. Workers' Compensation Reporter Series Decision Nos. 1–423.

After proclamation of the *Workers Compensation Amendment Act*, 1989, the published policies of the Governors shall consist of the documents listed above, amendments to the three policy manuals, any new or replacement manuals issued by the Governors and all decisions of the Governors declared to be policy decisions.

In the event of a conflict between the ~~Act~~ **Act** or Regulations and the published policy of the Governors, the ~~Act~~ **Act** and Regulations are paramount.

In the event of an internal conflict in published policy of the Governors, the interpretation of the policy most consistent with the intention of the ~~Act~~ **Act** or Regulations is to be applied.

Decision #3 of the Governors also provides that the Chairman of the Governors will supervise the continuation of the Workers' Compensation Reporter Series. The Reporter Series will include decisions of the Governors and selected decisions of the Appeal Division. It may also include key decisions of the review board and the courts on matters affecting the interpretation and administration of the ~~Act~~ **Act** or other matters of interest to the community.

The publication of a decision or finding in the Workers' Compensation Reporter Series does not make that decision or finding a published policy of the Governors. Only the documents outlined above are the published policy of the Governors. While decisions of the courts and the Appeal Division and findings of the review board may be published in the Workers' Compensation Reporter Series, their publication does not turn them into published policy of the Governors.

The Board is not bound to follow legal precedent; its decision shall be given according to the merits and justice of the case. (22 18)

In the adjudication of individual claims, the Board is not "bound" by either internal policy directives or by external authorities in the field of compensation, at least not in the sense of the word "bound" as understood at common law. However, in issuing internal directives, the Board gives general indications of how it will act when certain circumstances come before it. When these circumstances arise, the applicable directive will normally be followed. It is recognized that there is an infinite variety of circumstances that can arise and that it is not possible to lay down in advance policies to finally determine every conceivable situation. Furthermore, there is the obligation on the Board to decide each case in accordance with its merits and justice and the right of individual persons affected

under the rules of natural justice to present argument and evidence on their own behalf. Therefore, regard must always be had to the particular circumstances of each claim to determine whether an existing policy should be applied or whether there are grounds for a change in or departure from a policy. There will also be situations arising from time to time which are not covered by existing policy.

Board officers making decisions on claims are generally required to follow Board policies which are applicable to a claim before them. If they feel that a change in, or departure from a policy would be desirable, or they can find no applicable policy, they may refer the matter, with the approval of their Manager, to the Director of their department or the Director's delegate. They are required to exercise discretion in referring such matters to their Director when the practical implications are nominal and the "policy" issue effects only an extremely small number of potential future claims. If it is an unusual situation that is unlikely to occur again, or the administrative costs of reviewing the matter far outweigh the dollars on the claim, it is not considered that a referral for policy direction is necessary. This does not apply however when there is a serious concern over a small claim which represents a broad issue of policy, or over a large claim in financial terms which represent a relatively small issue of policy.

#96.20 Claims Officers and Claims Adjudicators

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

Following acceptance of a claim, the Claims Officer or Claims Adjudicator determines the amount and duration of compensation to be paid for temporary disability.

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

The term "compensation" here includes, among other things, health care benefits, transportation and subsistence. For administrative purposes, and with the approval from the Claims Adjudicator or Claims Officer, Payment Clerks and other authorized staff may return to workers, with an explanatory letter, items such as transportation receipts, drug accounts, etc. which do not appear to qualify for payment on a claim. This is an interim measure only to the extent that, should a worker disagree, the Claims Adjudicator or Claims Officer must make a formal decision which, if negative, is appealable.

It is the responsibility of Claims Adjudicators and Claims Officers to determine whether a worker's claim should be referred to the Disability Awards Department for review and possible ~~pension~~ **permanent disability** evaluation. This decision is generally made on the basis of information supplied by a treating physician, qualified practitioner, consulting specialist or the injured worker. Treating physicians and qualified practitioners are required to send periodic reports to the Board outlining the worker's condition. These reports include a question which asks specifically whether there will be any permanent disability resulting from the injury.

To ensure consistent referrals of all cases where there is a potential permanent disability, the Claims Adjudicator or Claims Officer is required to refer the claim to the Disability Awards Department for further evaluation where any of the following guidelines apply:

1. Where a medical report indicates that a permanent disability exists or that there is a possibility a permanent disability exists.
2. Where a worker indicates there is a permanent disability as a result of the compensable injury, or states there is an inability to return to employment as a consequence of the injury.
3. Where there is any other indication of a permanent disability or potential permanent disability.

If there is any doubt about the existence of a permanent disability, these claims are referred to the Disability Awards Department for final consideration. Claims Adjudicators and Claims Officers, however, are expected to exercise discretion and common sense in deciding whether to refer a worker's claim to the Disability Awards Department. Once a decision is made to refer a claim to the Disability Awards Department, it is up to the Claims Adjudicator or Claims Officer to clearly delineate by memo the status of the claim and to confirm what conditions have been accepted.

#96.21 *Interim Adjudication*

An interim decision to allow a claim will be made when the following conditions are all present:

1. The worker appears to be currently disabled from work.
2. On the evidence at present available, it appears probable that the worker is suffering from a compensable injury or occupational disease, or at least it appears that the possibilities are evenly balanced.

3. There is some significant delay in obtaining the best evidence to arrive at a conclusion on the validity of the claim, and the Claims Adjudicator is unable to avoid that delay.
4. The worker is not causing the delay.
5. The delay appears to be causing an interruption of income. For example, the case is not one in which the worker is still being paid by the employer or another source.
6. The claim is not a third party one. (~~23~~ 19)

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

Where a claim is allowed on an interim basis, the following rules will apply:

1. Wage-loss benefits will be commenced, with an explanation to the claimant, employer and attending physician.
2. Payments of wage-loss benefits under the interim decision will commence as of the date when the Adjudicator makes the interim decision. Arrears of wage-loss benefits for any time period prior to that date will not be paid until the final decision on the validity of the claim, except that the Adjudicator may pay such arrears on an interim decision to the extent that this may be necessary to avoid hardship.
3. The Adjudicator will proceed to obtain the best evidence to reach a final conclusion on the claim as soon as possible.
4. Health care benefit bills will not be paid under an interim decision. Where a claim has been accepted on an interim adjudication basis and there has been a request for surgery, it will be handled in the same manner as with other claims that have yet to be formally adjudicated. In such cases, the patient and physician should proceed privately, pending a final decision on the claim. This principle also applies with respect to other medical referrals, with the exception of a consultation with a specialist which may be paid on an investigation basis.
5. Where payments have been commenced on an interim basis, and the final decision is to disallow the claim, then:
 - (a) no recovery of the payments will be made in the absence of fraud or misrepresentation;

- (b) the employer's sector or rate group will be relieved of the cost of any unrecovered payments pursuant to **policy item #113.10**.

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

#96.22 *Suspension of Claim*

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

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

Where a claim file is opened, and it is later established that the claim will be fully administered and paid by another Board under the terms of the Interjurisdictional Agreement, the British Columbia file will be placed in suspense. (**24 20**)

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

1. where the ~~claimant~~ **worker** leaves the province without notifying the Board or receiving prior consent from the Board; (**25 21**)
2. where the ~~claimant~~ **worker** is being paid full salary by the Federal Government; (**26 22**)
3. where the ~~claimant~~ **worker** refuses to accept the cheques;
4. where a worker moves and the worker's whereabouts are unknown.

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

~~**#96.23** *Withholding Wage-loss Benefits Pending Investigation*~~

~~Once the Board has made an initial decision to accept a claim and pay wage-loss benefits, these benefits are usually paid on a regular basis for as long as the Board continues to receive medical reports showing disability. Furthermore,~~

~~benefits will not be suspended simply because of a lack of medical reports. Although it is the responsibility of the worker to seek required medical attention so that the necessary ongoing proof of disability can be submitted by her or his doctor, it is not the responsibility of the worker to procure these reports. While the worker's assistance is often requested, the final responsibility for obtaining the reports rests with the Board.~~

~~The Board will use its best efforts to obtain necessary reports and carry out investigations as quickly as possible so that there is no delay in the payment of benefits. However, it may be that in some cases there will be delays where the necessary investigations cannot be carried out in time. The Board must be satisfied before it makes any payment of wage loss that the requirements of the Act are met and may withhold benefits temporarily until it is able to satisfy itself of this. Even if there are medical reports on file indicating that the claimant is disabled, there may be other information indicating that this is not the case, for example, that he or she is working, which may require that benefits be withheld pending investigation. The highest priority is given to investigations which are causing a delay in benefits. The claimant is notified of any significant delays because of the need to carry out investigation.~~

#96.30 Disability Awards Officers and Adjudicators in Disability Awards

Disability Awards Officers and Adjudicators in Disability Awards determine whether a worker's injury or occupational disease has caused a permanent disability. They then decide the extent of the disability and calculate the worker's pension **permanent disability award** entitlement. Disability Awards Officers and Adjudicators in Disability Awards must accept the final decision of the Claims Adjudicator as to what conditions are accepted under the claim. The Claims Adjudicator is required to outline the decision in a memo when referring the claim to the Disability Awards Officer or Adjudicator in Disability Awards.

In cases of minor disabilities, the Disability Awards Officer or Adjudicator 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 permanent functional impairment evaluation to be conducted for disability awards purposes by a Disability Awards Medical Advisor or an authorized External Service Provider (see **policy item #38.10**).

Although the evaluation is not the only medical evidence that the Disability Awards Officer or Adjudicator 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 #38.10**.

There may be cases where the Disability Awards Officer or Adjudicator in Disability Awards will be able to conclude from the information on the claim that there is no compensable permanent disability resulting from the injury.

Where, after reviewing a claim, the Disability Awards Officer or Adjudicator in Disability Awards decides there is no permanent disability, it is not necessary to inform the worker of this conclusion unless it is evident the worker has enquired about entitlement or expressed some expectations of receiving an award. The above process is considered an extension of the referral initiated by the Claims Adjudicator or Claims Officer.

There are also borderline situations where the Disability Awards Officer or Adjudicator in Disability Awards may seek advice or clarification from the Disability Awards Medical Advisor concerning the question of potential disability. If, after this process, the Disability Awards Officer or Adjudicator in Disability Awards concludes that no disability is evident, it is not necessary to advise the worker of this conclusion, unless there has been a specific enquiry or it is evident that the worker has expectations of receiving an award.

However, in those cases where the worker has a permanent functional impairment evaluation, the Disability Awards Officer or Adjudicator in Disability Awards is required to notify the worker indicating the results of the evaluation and the conclusions reached regarding the question of ~~pension~~ **permanent disability award** entitlement.

The final decision on the assessment of a ~~pension~~ **permanent disability award** on a projected loss of earnings basis 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 ~~pensions~~ **permanent disability awards** are adjudicated in the first instance by Adjudicators in Disability Awards. Before making a decision, they may ask the Rehabilitation Consultant to contact the claimant and obtain the necessary information.

#97.00 EVIDENCE

Under the old English system, which was an adversary system of workers' compensation, there was a burden of proof imposed on the worker, but that is not the correct practice here. The Claims Adjudicator must not start with any presumption against the worker, but neither must there be any presumption in the worker's favour. The correct approach is to examine the evidence to see whether it is sufficiently complete and reliable to arrive at a sound conclusion with confidence. If not, the Adjudicator should consider what other evidence might be obtained, and must take the initiative in seeking further evidence. After that has been done, if, on weighing the available evidence, there is then a preponderance

in favour of one view over the other, that is the conclusion that must be reached. But if it appears upon the weighing of the evidence that the disputed possibilities are evenly balanced then the rule comes into play which requires that the issue be resolved in accordance with that possibility which is favourable to the worker.

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

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

#97.10 Disputed Possibilities Evenly Balanced

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

Under the terms of Section 99, the Board is required to decide an issue in accordance with the possibility which is favourable to the worker where it appears that "the disputed possibilities are evenly balanced". This applies only where there is evidence of roughly equal weight for and against the claim. It

does not come into play where the evidence indicates that one possibility is more likely than the other. (27 23)

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

#97.20 Presumptions

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

1. In cases where the injury is caused by accident, where the accident arose out of the employment, unless the contrary is shown, it shall be presumed that it occurred in the course of the employment; and where the accident occurred in the course of the employment, unless the contrary is shown, it shall be presumed that it arose out of the employment. (28 24)
2. If the worker at or immediately before the date of disablement was employed in a process or industry mentioned in the second column of Schedule B, and the disease contracted is the disease in the first column of the schedule set opposite to the description of the process, the disease shall be deemed to have been due to the nature of that employment unless the contrary is proved. (29 25)
3. Where a deceased worker was, at the date of death, under the age of 70 years and suffering from an occupational disease of a type that impairs the capacity or function of the lungs, and where the death was caused by some ailment or impairment of the lungs or heart of non-traumatic origin, it shall be conclusively presumed that the death resulted from the occupational disease. (30 26)

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

#97.31 *Matter Requiring Medical Expertise*

Where the matter is one requiring medical expertise, the decision must be preceded by a consideration of medical evidence (this term includes medical opinion or advice). Medical evidence might consist of a statement in the Form 8 Physician's First Report, (~~34~~ **27**) or some information or opinion from the attending physician, or it might consist of advice from a Board Medical Advisor or another doctor. It is for the Claims Adjudicator or Claims Officer to decide when medical evidence is needed, what kind of medical evidence is needed, and on what questions.

#97.34 *Conflict of Medical Opinion*

Where there are differences of opinion among doctors, or other conflicts of medical evidence, the Adjudicator must select among them as best she or he can. The Adjudicator must not do it by automatically preferring the opinions of one category of doctors to another category, nor should it be done by counting heads, so many opinions one way and so many another. The Adjudicator must analyze the opinions and conflicts as best as possible on each issue and arrive at her or his own conclusions about where the preponderance of the evidence lies. If it is concluded that there is doubt on any issue, and that the possibilities are evenly balanced, the Adjudicator must follow the mandate of Section 99 and resolve that issue in accordance with the possibility that is most favourable to the worker. (~~32~~ **28**)

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

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

The Board has no rule which states that the evidence of a physician is always to be preferred to that of a chiropractor or other qualified practitioner. Reports from

both types of practitioner are acceptable evidence and are weighed on their merits. This principle applies even if the referral to the practitioner is contrary to Board policy. Should there, for example, be concurrent treatment by a physician and a chiropractor, the Board might not pay for the chiropractor, but any chiropractor reports received must be weighed as evidence. They are not ignored just because the referral was unauthorized. (33 29)

#97.40 Disability Awards

In cases of very minor disabilities, Disability Awards Officers or Adjudicators in Disability Awards may proceed to calculate a disability award without a permanent functional impairment evaluation, if they consider that this is unnecessary having regard to the medical evidence already available. Except for those cases, the normal practice is for a permanent functional impairment evaluation to be conducted for disability awards purposes by a Disability Awards Medical Advisor or an External Service Provider.

It is the responsibility of the Disability Awards Officer or Adjudicator to classify the disability as a percentage of total disability. In doing this, it is proper for the Disability Awards Officer or Adjudicator to consider other factual and medical evidence as well as the report of the Disability Awards Medical Advisor or the External Service Provider. However, although the report of the Disability Awards Medical Advisor or the External Service Provider is not the only medical input that a Disability Awards Officer or Adjudicator may use, it will usually be the primary input, and caution will be used in referring to any other medical opinion.

The report of a Disability Awards Medical Advisor or External Service Provider takes the form of expert evidence which, in the absence of other expert evidence to the contrary, should not be disregarded. This does not mean that a Disability Awards Officer or Adjudicator must adopt the percentage indicated by the Disability Awards Medical Advisor or External Service Provider. It is always open to the Disability Awards Officer or Adjudicator to conclude that, although the functional impairment of the claimant is a certain percentage, the disability (i.e. the extent to which that impairment affects the claimant's ability to earn a living) is greater or less than the percentage of impairment.

The decision-making procedure for assessing entitlement to a permanent disability award for psychological impairment under Section 23(1) of the *Act* is discussed in **policy** item #38.10.

In making a determination under Section 23(1), the Disability Awards Officer or Adjudicator will enquire carefully into all of the circumstances of a worker's condition resulting from a compensable injury. This means that both the objective physical findings noted by the examining doctors and the worker's subjective complaints of pain will be considered. The fact that the complaints are largely subjective does not automatically preclude a finding that a worker has a

disability within the meaning of Section 23(1). Nor, on the other hand, does the fact that subjective complaints exist automatically warrant a finding of disability. In all cases, a decision must be made on the particular facts of the claim as to whether or not a disability exists.

With regard to the question as to what type of evidence will be sufficient to justify a conclusion that a permanent disability exists in these cases, it is not possible to lay down an exclusive list. However, some suggestions can be made. There will, in the first place, be the claimant's own evidence regarding the nature and extent of her or his complaints and whether that evidence is credible and consistent. Regard must also be had to the claimant's conduct and activities and whether they are consistent with the complaints. There will then be the evaluations of the claimant by the various professional personnel and Board's staff who have been involved in the case, for example, doctors, psychologists, rehabilitation consultants, and assessors in the Board's ~~Industrial Department~~ **Rehabilitation Centre**. Consideration will have to be given to the objective observations of these persons as well as their subjective assessments. They may be able to comment on whether the claimant's complaints are of a type and extent that might reasonably result from the type of injury which was suffered.

When there is little clinical evidence of objective impairment, extreme caution must be exercised in concluding that there is a permanent disability resulting from that injury. The evidence that is relied upon to support the assessment of such an award must be fully documented. It must clearly demonstrate that there is a permanent disability for which the payment of a ~~pension~~ **permanent disability** award may be supported.

#98.10 Powers of the Board

Section 87 of the *Act* provides as follows:

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

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

#98.11 *Powers of Officers of the Board*

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

The officer and every other person appointed to make an inquiry has for the purposes of an inquiry under Subsection (1), and the review board has, all the powers conferred upon the Board by Section 87. (34 30)

Every officer or person authorized by the Board to make examination or inquiry under this section may require and take affidavits, affirmations or declarations as to any matter of the examination or inquiry, and take affidavits for the purposes of this ~~Act~~ **Act**, and in all those cases to administer oaths, affirmations, and declarations and certify that they were made. (35 31)

Section 71(8) provides that “An officer of the board may investigate an accident resulting in injury to, or the death of, a worker, and may inspect and inquire with respect to health and safety matters at any place of employment, and may make the inquiries and inspect the documents he or she considers necessary for these purposes, and any employer, worker or other person who withholds information from the officer making inquiries, or who otherwise obstructs or interferes with the officer in the exercise of the officer's functions under this section, commits an offence and is liable on conviction to a fine not exceeding . . .” the amount set out in Part 3 of Appendix 6, “. . . or to imprisonment not exceeding 3 months, or to both.”

The Board has ruled that, for the purpose of Sections 88 and 71, employees of the Board, who, in the performance of their prescribed duties, do those things which are reserved to be done by an officer of the Board, are, and have been, for matters arising out of Part 1 of the ~~Act~~ **Act**, appointed officers of the Board.

#98.12 *Examination of Books and Accounts of Employer*

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

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

An employer and every other person who obstructs or hinders the making of an examination or inquiry mentioned in Subsection (3), or who refuses to permit it to be made, or who neglects or refuses to produce the documents, writings, books, deeds, and papers at the place and time stated in the notice mentioned in Subsection (3), commits an offence. (~~36~~ **32**) The maximum fine for committing this offence is set out in Part 1 of Appendix 6.

#98.13 *Medical Examinations and Opinions*

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

The medical resources of the Board cannot be used to provide a medical opinion to anyone on request. A Board Medical Advisor will, therefore, decline to provide a medical opinion if the request does not come from someone authorized to make the request. Those authorized are officers of the Board responsible for claims decisions, other Board staff where duties require an input of medical advice, members of the review board, and members of the Appeal Division. Advice to treating doctors may, however, be provided according to the judgment of the Board Medical Advisor.

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

#98.20 **Conduct of Inquiries**

The Board operates on an inquiry as opposed to an adversary system. It does not, like a court operating under the adversary system, decide between the arguments and evidence submitted by two opposing parties at a hearing and limit itself to the material presented at that hearing. While the judge under the adversary system has little or no authority to carry out investigations, the Board is obliged by Section 96 of the ~~Act~~ **Act** both to investigate and to adjudicate claims for compensation. Oral hearings or interviews are not always conducted before a decision is reached and, when they are conducted, provide only part of the information relied on by the Board. The other written reports on the file will also be considered. Such hearings are informal in nature and not subject to the formal rules of evidence and procedure followed in court hearings.

#98.25 Oaths

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

If:

1. a person called to give evidence objects to taking an oath, or is objected to as incompetent to take an oath, and the Board is satisfied of the sincerity of the objection of the witness from conscientious motives to be sworn or that the taking of an oath would have no binding effect on his or her conscience; or
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. (~~37~~ **33**) An employer or representative or a claimant's representative need not be placed under oath unless they have something specific or pertinent to contribute to the inquiry.

#99.00 DISCLOSURE OF INFORMATION

The Workers' Compensation Board, for the purposes of administering the *Workers Compensation Act* (~~Act~~ **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* (F.I.P.P.) provides access for the public to the information maintained by the Board while at the same time protecting personal privacy.

F.I.P.P. 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 F.I.P.P., 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 sometimes contain personal and sensitive information. The privacy provisions of F.I.P.P. will, therefore, prevail other than for the specific exceptions contained in F.I.P.P. 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 Section 33 such as the need to comply with the requirements of a specific ~~Act~~ **Act**. The statutory access to records by the Ombudsman, appeal bodies or the Workers' and Employers' Advisers remains unchanged.

Section 3(2) of the *Freedom of Information and Protection of Privacy Act* states that the ~~Act~~ **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 appeal.

Before an appeal is initiated, the WCB must apply F.I.P.P. 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 F.I.P.P. rules. Before an 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 an 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 F.I.P.P. 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 F.I.P.P. Department of the Board. These requests will be considered on an individual basis in accordance with F.I.P.P.

Dispute Resolution

A request for a review of the F.I.P.P. 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 Chairman, as the head of the W.C.B., has ultimate responsibility within the Board for implementation of F.I.P.P. for the purposes of workers' compensation.

RELEVANT SECTIONS OF F.I.P.P. HAVE BEEN REPRODUCED BELOW FOR THE CONVENIENCE OF THOSE USING THIS MANUAL.

Section 3 Scope of this Act

- (2) This ~~Act~~ **Act** does not limit the information available by law to a party to a proceeding.

Section 25 Information must be disclosed if in the public interest

- (1) Whether or not a request for access is made, the head of a public body must, without delay, disclose to the public, to an affected group of people or to an applicant, information
 - (a) about a risk of significant harm to the environment or to the health or safety of the public or group of people, or
 - (b) the disclosure of which is, for any other reason, clearly in the public interest.
- (2) Subsection (1) applies despite any other provision of this ~~Act~~ **Act**.
- (3) Before disclosing information under subsection (1), the head of a public body must, if practicable, notify
 - (a) any third party to whom the information relates, and
 - (b) the commissioner.
- (4) If it is not practicable to comply with subsection (3), the head of the public body must mail a notice of disclosure in the prescribed form
 - (a) to the last known address of the third party, and
 - (b) to the commissioner.

Section 26 Purpose for which personal information may be collected

No personal information may be collected by or for a public body unless

- (a) the collection of that information is expressly authorized by or under an ~~Act~~ **Act**,
- (b) that information is collected for the purposes of law enforcement, or
- (c) that information relates directly to and is necessary for an operating program or activity of the public body.

Section 31 Retention of personal information

If a public body uses an individual's personal information to make a decision that directly affects the individual, the public body must retain that information for at

least one year after using it so that the individual has a reasonable opportunity to obtain access to it.

Section 35 Disclosure for research or statistical purposes

A public body 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 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 head of the public body concerned has approved conditions relating to the following:
 - (i) security and confidentiality;
 - (ii) the removal or destruction of individual identifiers at the earliest reasonable time;
 - (iii) the prohibition of any subsequent use or disclosure of that information in individually identifiable form without the express authorization of that public body, and
- (d) the person to whom that information is disclosed has signed an agreement to comply with the approved conditions, this ~~Act~~ **Act** and any of the public body's policies and procedures relating to the confidentiality of personal information.

Relevance of F.I.P.P. to Policy Items

Various items in the Manual deal with policies affecting disclosure or privacy. These are listed below with the appropriate sections of F.I.P.P. relevant to these policies.

Policy Item	Description	F.I.P.P. Reference	Other Reference
45.43	Starting a Business	33(b)	
45.50	Decision-Making Procedures	33(d)	W.C. Act, Sec. 35, 86 and 96
48.20	Money Owing in Respect of Benefits Paid by Other Agencies	33(b)	
48.22	Welfare Payments	33(l)	
48.30	Worker Not Supporting Dependents	3(2) and 22(2)(c), 33(a), (c), (d), (e) and 34	W.C. Act, Sec. 98
49.00	Incapacity Of A Claimant	33(d)	W.C. Act, Sec. 12 and 35(1)
49.13	Application of Section 35(5) in Cases of Temporary Disability	33(d)	W.C. Act, Sec. 35(5)
49.14	Application of Section 35(5) in Cases of Permanent Disability	33(d)	W.C. Act, Sec. 35(5)
49.15	Application of Section 35(5) on a Change of Circumstances	33(d)	W.C. Act, Sec. 35(5)
49.20	Imprisonment of Worker	33(d)	W.C. Act, Sec. 35 and 98(3)
53.10	Person to Whom Expenses are Paid	21, 22, 33(a), (d) and 33(i)(ii) and 34	W.C. Act, Sec. 17
58.00	Foster-Parents	33(d)	W.C. Act, Sec. 17(3)
74.23	Examination by the Board	33(d)	W.C. Act, Sec. 21
74.50	Selection of Physician or Qualified Practitioner	33(d)	W.C. Act, Sec. 21
78.21	Examination at the Board	33(c), 33(d) and 33(i)(ii)	W.C. Act, Sec. 21
78.22	Consultation with Specialists	33(d)	W.C. Act, Sec. 21
78.31	Adjudication of Health Care Benefits Accounts	33(c), (d) and 33(i)(ii)	W.C. Act, Sec. 21
78.32	Reversal of Decision on Appeal	33(c), (d) and 33(i)(ii)	W.C. Act, Sec. 21
87.10	Consultative Process	33(c) and (d)	W.C. Act, Sec. 16
94.12	What Injuries Must Be Reported	26 and 27	

Policy Item	Description	F.I.P.P. Reference	Other Reference
96.22	Suspension of Claim	3(2), 33(c), (d) and (i)(ii)	W.C. Act, Sec. 16, 21 and Div. 4
98.13	Medical Examinations and Opinions	33(d)	W.C. Act, Sec. 21
98.23	Representation	33(d)	W.C. Act, Sec. 88 and 96
98.24	Presence of Employer	3(2) and 33(d)	W.C. Act, Sec. 88 and 96
98.26	Witnesses and Other Evidence	27	
98.27	Cross-examination	27	
99.10	Disclosure of Issues Prior to Adjudication	3(2), 33(b), (c), (d), (l) and 34	W.C. Act, Div. 4, Sec. 90, 91 and 95
99.20	Notification of Decisions	3(2), 22, 33(b), (c), (d), (i) and 34	W.C. Act, Div. 4, Sec. 95
99.21	Notification of Right of Appeal	3(2)	
99.22	Procedure for Handling Complaints or Inquiries About a Decision	33(b), (d) and (i)	W.C. Act, Div. 4, Sec. 95
99.23A	Unsolicited Information — Anonymous	15, 19(1)(a), (b)	
99.23B	Unsolicited Information — Identified	19(2), 31 and 33	
99.24	Notification of Permanent Disability Pension Awards	3(2), 33(c) and (d)	W.C. Act, Div. 4, Sec. 90 and 91
99.31	Eligibility for Disclosure	Part 2, 3(2), 22(2)(c), 33(b), (c), (d) and (l)	W.C. Act, Div. 4, Sec. 95
99.32	Provisions of Copies of File Documents	33(b), (d) and 75	W.C. Act, Div. 4, Sec. 95
99.33	Personal Inspection of Files	9	
99.35	Complaints Regarding File Contents	29(3)	
99.40	Tape Recordings of Interviews	4(1) and 33(d)	W.C. Act, Div. 4, Sec. 95
99.41	Transcripts of Workers' Compensation Review Board Hearings	3(2), 4(1) and 33(d)	W.C. Act, Div. 4, Sec. 95

Policy Item	Description	F.I.P.P. Reference	Other Reference
99.50	Disclosure to Public or Private Agencies	33(b), (d), (e), (k), and (p)	W.C. Act, Sec. 95
99.51	Legal Matters	3(2), 33(d) and (e)	
99.52	Other Workers' Compensation Boards	33(d)	W.C. Act, Sec. 8(2)
99.53	The Canada Employment and Immigration Commission	33(b) and 33(d)	U.I. Act, Sec. 94(11)
99.55	Ministry of Social Services	33(i)(ii)	
99.56	Police	33(b), (n) and (q)	
99.60	Information to Other Board Departments	25 and 33(f)	
99.80	Insurance Companies	33(b)	
99.90	Disclosure for Research or Statistical Purposes	34	
102.32	Initiation of Appeal	3(2)	
102.41	Board Files	3(1)(b)	
102.42	Oral Hearings	4(1)	
102.50	Referral of Review Board Findings	3(2)	
103.92	Disclosure and the Freedom of Information and Protection of Privacy Act	33(a) and 19(2)	W.C. Act ss. 58 to 65
105.10	Appeals to the Workers' Compensation Review Board — New Claims	3(2)	
107.10	Distinction Between Reopening and New Claim	3(2)	
108.30	Readjudication Within the Compensation Services Division	3(2), 22(2)(c) and 33(d)	W.C. Act, Div. 4, Sec. 21, 90 and 91
109.10	Workers' Advisers	33(d)	W.C. Act, Sec. 95
109.20	Employers' Advisers	33(d)	W.C. Act, Sec. 95
109.30	Ombudsman	33(d)	Ombudsman Act, Sec. 15
111.25	Pursuing of Subrogated Actions by the Board	3(2) and 33(f)	
111.40	Certification to Court	33(d)	W.C. Act, Sec. 11

Policy Item	Description	F.I.P.P. Reference	Other Reference
113.00	Introduction	33(d)	W.C. Act, Div. 4, Sec. 42 and 47
113.20	Occupational Diseases	3(2)	
114.43	Procedure Governing Applications under Section 39(1)(e)	3(2)	
115.11	Procedure for Applying Section 47(2)	33(d) and 33(i)	W.C. Act, Sec. 47(2)
115.31	Injuries or Aggravations Occurring in the Course of Treatment or Rehabilitation	3(2)	

Section 95(1) of the ~~Act~~ **Act** provides that “Officers of the board and persons authorized to make examinations or inquiries under this Part must not divulge or allow to be divulged, except in the performance of their duties or under the authority of the board, information obtained by them or which has come to their knowledge in making or in connection with an examination or inquiry . . .”

It further provides:

- (1.1) If information in a claim file, or in any other material pertaining to the claim of an injured or disabled worker, is disclosed for the purpose of this ~~Act~~ **Act** by an officer or employee of the board to a person other than the worker, that person shall not disclose the information except
 - (a) if anyone whom the information is about has identified the information and consented, in the manner required by the board, to its disclosure,
 - (b) in compliance with an enactment of British Columbia or Canada,
 - (c) in compliance with a subpoena, warrant or order issued or made by a court, person or body with jurisdiction to compel the production of information, or
 - (d) for the purpose of preparing a submission or argument for a proceeding under this Part.
- (1.2) No court, tribunal or other body may admit into evidence any information that is disclosed in violation of subsection (1.1).

Every person who violates Subsection (1) of (1.1) commits an offence. (38 34)
The maximum fine for this offence is set out in Part 1 of Appendix 6.

#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 the allowance is sent to any advocate designated by the claimant's designated union or association who is acting on behalf of the claimant. Information may also be disclosed to any other advocate, representative or other person where authorized in writing by the claimant.

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 will be provided to the employer. 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 claimant, the reasons are stated in a letter to the claimant. The guidelines set out below apply in writing these letters. The Claims Adjudicator 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 balance of possibilities.
- 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 the standard appeal paragraph.

A copy of the decision letter will be sent to the employer, and to any advocate designated by the claimant's union or association who is acting on behalf of the claimant. Information may also be disclosed to any other advocate, representative or other person where authorized in writing by the claimant. A copy may also be sent to the physician where the decision involves medical factors. In all other cases, such as, a notification to a pharmacy, a simple letter or notification will be sent.

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 claimant was employed by an employer not covered under the **Act** **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" as the result of a recurrence of disability, the employer is notified of the decision either directly or by receiving a copy of the notification sent to the worker.

#99.21 *Notification of Right of Appeal*

In any case where an adverse and appealable decision is made with regard to a worker, the worker will be informed of rights of appeal. The employer will be informed of rights of 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, the appeal pamphlet will be sent to the employer. If a claim is rejected on the basis that it did not

involve an employer covered under the ~~Act~~ **Act** or there was no personal optional protection in force, notification of the 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 appeal information are sent to the employers' association that best represents the appropriate sector and rate group of industry.

#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, employer or representative is requesting further explanation, this should be given. In the case of representatives, it will require an authorization except where an advocate designated by the claimant's union or association is acting on behalf of the claimant. Where, however, dissatisfaction is expressed with the substance of the decision, the procedure outlined below 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 Compensation Services Division.

1. Where a Medical Appeals Officer dealing with an appeal to a Medical Review Panel receives new evidence from a worker, employer or representative in respect of a decision that he or she has made or where an error in the decision is pointed out by one of those parties and the Medical Appeals Officer feels that the decision should be changed, he or she will do so. (~~39~~ **35**) Where a Claims Adjudicator, Disability Awards Officer or Adjudicator in Disability Awards considers that a decision he or she has made should be changed as a result of new evidence being presented or an error being pointed out, he or she will follow the readjudication procedures set out in **policy item #108.30**.

2. (a) Where a Claims Adjudicator, Disability Awards Officer, Adjudicator in Disability Awards or Medical Appeals Officer receives a letter from a worker, employer or representative expressing

dissatisfaction with the substance of a decision he or she has made and does not feel that the decision should be changed, the letter will be treated as an appeal from the decision and forward it with the claim to the review board. The worker, employer or representative will be advised in writing that this action is being taken and that the review board will contact them further. Where, during a telephone call or visit, a worker, an employer or representative expresses dissatisfaction with the substance of the decision, the Claims Adjudicator, Disability Awards Officer, Adjudicator in Disability Awards or Medical Appeals Officer will refer the party to the pamphlet explaining appeals to the review board and suggest that an appeal be submitted by either filling out an appeal form or submitting a letter of appeal.

(b) Where a Claims Adjudicator, Disability Awards Officer, Adjudicator in Disability Awards or a Medical Appeals Officer receives a letter, telephone call or visit from a person who is not the worker or representative, for example, a family member, and who is expressing dissatisfaction with the decision on behalf of the worker, the party in question will be asked to have the worker appeal. In such cases the details of the claim will not be discussed unless the worker has authorized in writing access to their personal information by that individual.

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.

#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 Pension 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 the standard notification regarding the right of appeal.

Other than to the employer or the worker, the amount being paid per month for a ~~pension~~ **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.

#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 an appeal has been initiated, an employer may obtain disclosure. An employer may obtain disclosure even though the worker has not requested disclosure. Disclosure to an employer may be obtained where the President has referred a review board finding to the Appeal Division under Section 96(4) of the ~~Act~~ **Act.**

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

A written request for disclosure must be received from each party who wants it. Where a claimant only submits a written request, disclosure will not automatically be granted to the employer in the absence of a separate written request, and vice versa.

Where there is a valid 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 appealable decision or the issue under 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 an appeal, file updates are automatically provided up to the time the appeal is heard. The file may be inspected if it is so desired.

#99.34 *Procedure for Requesting Disclosure*

Where an appeal has been filed, employers' or workers' requests for disclosure must be submitted, together with any necessary authorization of a representative, to the Records Management Section, Workers' Compensation Board, 6951 Westminster Highway, Richmond, BC, V7C 1C6. If it is not an 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**).

#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 ~~pension~~ **permanent disability award** being paid to a claimant **worker** by this Board.

#99.53 *The Canada Employment and Immigration Commission*

In referring workers to Canada Employment Centres for assistance in job placement, a Rehabilitation Consultant may, with the worker's signed consent, furnish the agency with a brief description of their physical limitations.

The *Unemployment Insurance Act* contains a provision in Section 94(11) which gives the Commission the statutory authority to require the disclosure of information necessary for the administration of the ~~Act~~ **Act**. Information will, therefore, be provided where a formal demand in accordance with Section 94(11)

is received from the Commission in connection with a claim for Employment Insurance.

#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**.

#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 inquiries or appeal hearings. 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**.

#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.

#100.13 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 ~~in the Rehabilitation Residence (40)~~ may be offered if required. **Policy item #100.15** applies where the worker resides outside the province.

#100.14 Amount of Expenses

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

#100.15 *Claimant Resides Outside the Province*

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

Where workers resident outside the province are specifically requested by the Board, the Review Board or the Appeal Division to travel from their home to attend a claims or appeal inquiry or the Review Board or Appeal Division decides to pay expenses under **policy item #100.12** after the conclusion of an appeal, the full cost of the trip will be paid by the Board. The fact that the Appeal Division or Review Board grants a worker's request for an oral hearing on his or her own appeal does not mean that the worker has been requested to attend for this purpose.

Where a worker resident outside the province appeals to a Medical Review Panel, the worker is advised that, following the receipt of the panel's certificate, the Board may decide to pay expenses for the whole journey. In reaching the decision, the Board considers the contents of the panel certificate.

If the Medical Review Panel appeal is initiated by the employer or the referral to the Medical Review Panel is made by the Board, the full costs of the journey will be paid.

#100.30 **Witnesses and Interpreters**

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

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

Where the expenses of a witness are payable, the amount will be the same as for a claimant. 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. ~~Prior to September 1, 1992, a special witness lost earnings allowance was paid as follows:~~

Witness Expenses

Date	Amount Per Half-Day
January 1, 1983 — December 31, 1983	\$36.96
January 1, 1984 — September 30, 1989	40.44
October 1, 1989 — February 28, 1991	47.00
March 1, 1991 — August 31, 1992	49.00

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

#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. (44-36) The Board will not pay the legal costs of a claimant 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 claimant **worker** incurs expense in producing evidence of a kind which the Adjudicator **Board officer** would have sought had it not been produced by the claimant **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 claimant **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 claimant **worker** or employer will also be paid by the Board where, following the inquiry or appeal, it appears reasonable for them or their representative to have assumed, prior to the inquiry or appeal, 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 claimant's **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 claimant's **worker's** attending physician at no cost. A simple request to the attending physician, together with a release from the claimant **worker**, would have been sufficient.

It is not the Board's intention that ~~claimants~~ **workers** or employers should incur costs in obtaining evidence, for example, accountants' fees for producing earnings information. Rather, the general approach is that the ~~claimant~~ **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).**

#100.70 The Awarding of Costs

The provisions in **policy item #100.00-60** 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~~ **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 an appeal by the worker or the employer. The appeal may be to the review board or the Appeal Division, but does not include a referral of the review board findings to the President as outlined in **policy item #102.50**. 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 an appeal but only in unusual cases. The section is limited to cases where the worker or employer abuses their respective rights under the ~~Act~~ **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 an appeal was pursued simply because the right of appeal 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 appeal. Where the appeal is not opposed by the other party, the reasons for not making an award become even stronger.

#100.71 Application for Costs by Dependant

On an application under Section 11 of the ~~Act~~ **Act**, the Board certified that the defendant to a third party action was not an employer under the ~~Act~~ **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~~ **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~~ **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.

#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** #100.00-50. 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.

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.50, prior to repeal by S.27, *Workmen's Compensation Amendment Act*, 1974 (hereafter referred to as W.C.A., 1974)~~
- ~~(6) See **policy item #93.22**~~
- (7 5) S.55(1)
- ~~(8) S.55(4)~~
- ~~(9) S.52, prior to repeal by S.29, W.C.A., 1974~~
- (10 6) S.55(1)
- (11 7) S.12; See **policy item #49.00**
- (12 8) S.54(2)
- (13 9) S.54(3)
- (14 10) S.54(6)(b)
- (15 11) S.54(9)
- (16 12) See **policy item #34.40**
- (17 13) See **policy item #74.10**
- (18 14) S.56(1)(b)
- (19 15) S.56(1)(c)
- (20 16) S.56(5)
- (21 17) S.56(1)(d)
- (22 18) S.99
- (23 19) See Chapter 16
- (24 20) See **policy item #112.30**; **policy item #113.30**
- (25 21) See **policy item #73.54**
- (26 22) See **policy item #34.40**
- (27 23) *Workers' Compensation Board of British Columbia, W.C.B. News Bulletin*, September – October, 1973
- (28 24) S.5(4); See **policy item #14.10**

- (~~29~~ **25**) S.6(3); See **policy item #26.21**
- (~~30~~ **26**) S.6(11); See **policy item #29.50**
- (~~31~~ **27**) See **policy item #95.10**
- (~~32~~ **28**) See **policy item #97.10**
- (~~33~~ **29**) See **policy item #74.60**
- (~~34~~ **30**) S.88(2)
- (~~35~~ **31**) S.88(4)
- (~~36~~ **32**) S.88(5)
- (~~37~~ **33**) S.21, *Evidence Act*
- (~~38~~ **34**) S.95(2)
- (~~39~~ **35**) See **policy item #103.00**
- ~~(40)~~ See #84.00
- (~~41~~ **36**) See **policy item #48.10**