REHABILITATION SERVICES & CLAIMS MANUAL

VOLUME II

Published by
WorkSafeBC
Province of British Columbia

Free electronic updates of the *Manual* are available at
https://www.worksafebc.com/en/law-policy/claims-rehabilitation/compensation-policies/rehab-claims-volumeii

ORGANIZATION OF THIS *MANUAL*

The *Rehabilitation Services & Claims Manual*, Volume II ("*Manual*") sets out the policies that relate to the Board's compensation and rehabilitation mandate.

This *Manual* comprises eighteen chapters and five appendices.

The material in the chapters is arranged logically according to subject matter and not in the same order as the *Workers Compensation Act* ("*Act*").

The *Manual* consists of a number of "Items" that relate to particular provisions. An explanation of how the Items are organized is found on the following page.

The policies of the board of directors include the statements under the heading "Policy" in the Items in this *Manual*. For greater clarity, the statements under the headings "Background" and "Practice", and the explanatory material at the end of each Item, do not constitute binding policies of the board of directors.

The Background section for Items reproduces relevant excerpts from the *Act*. The Explanatory Notes in the Background section provide helpful information but do not constitute binding policies of the board of directors. They do not alter the meaning of any policy. If there is a conflict between the policy in an Item and its Explanatory Notes, the policy prevails.

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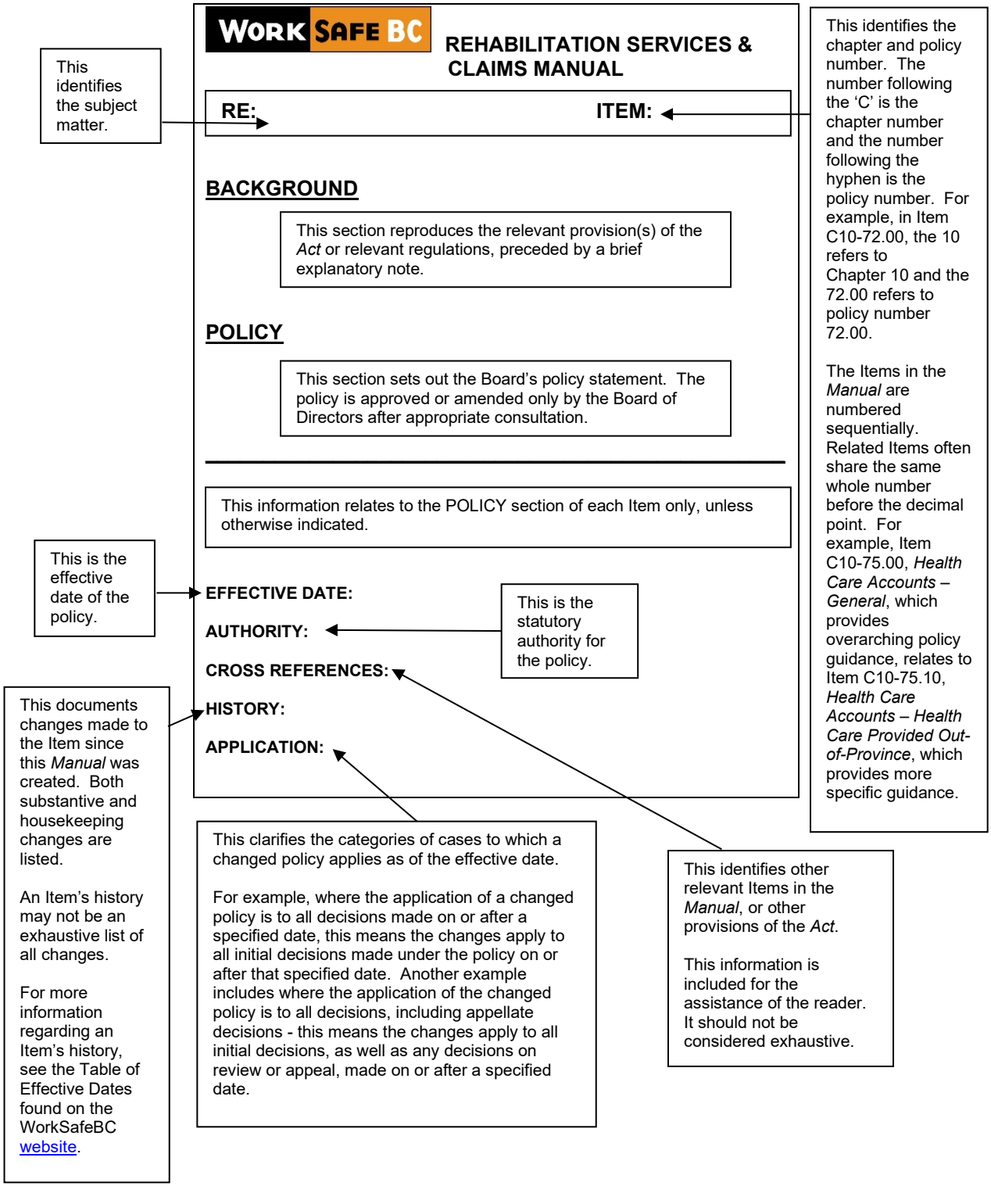
Practice Directives setting out additional guidance on the interpretation and application of the *Act* and/or policy can also be found on the WorkSafeBC website.


WORK SAFE BC
REHABILITATION SERVICES & CLAIMS MANUAL
This identifies the subject matter.
RE:
ITEM:
This identifies the chapter and policy number. The number following the 'C' is the chapter number and the number following the hyphen is the policy number. For example, in Item C10-72.00, the 10 refers to Chapter 10 and the 72.00 refers to policy number 72.00.
The Items in the Manual are numbered sequentially. Related Items often share the same whole number before the decimal point. For example, Item C10-75.00, Health Care Accounts – General, which provides overarching policy guidance, relates to Item C10-75.10, Health Care Accounts – Health Care Provided Out-of-Province, which provides more specific guidance.
BACKGROUND
This section reproduces the relevant provision(s) of the Act or relevant regulations, preceded by a brief explanatory note.
POLICY
This section sets out the Board's policy statement. The policy is approved or amended only by the Board of Directors after appropriate consultation.
This information relates to the POLICY section of each Item only, unless otherwise indicated.
This is the effective date of the policy.
EFFECTIVE DATE:
AUTHORITY:
This is the statutory authority for the policy.
CROSS REFERENCES:
HISTORY:
APPLICATION:
This documents changes made to the Item since this Manual was created. Both substantive and housekeeping changes are listed.
An Item's history may not be an exhaustive list of all changes.
For more information regarding an Item's history, see the Table of Effective Dates found on the WorkSafeBC website.
This clarifies the categories of cases to which a changed policy applies as of the effective date.
For example, where the application of a changed policy is to all decisions made on or after a specified date, this means the changes apply to all initial decisions made under the policy on or after that specified date. Another example includes where the application of the changed policy is to all decisions, including appellate decisions - this means the changes apply to all initial decisions, as well as any decisions on review or appeal, made on or after a specified date.
This identifies other relevant Items in the Manual, or other provisions of the Act.
This information is included for the assistance of the reader. It should not be considered exhaustive.

PREFACE

Section 319 of the *Workers Compensation Act* provides that the Board of Directors of the Workers' Compensation Board must set and revise as necessary the policies of the Board of Directors, including policies respecting occupational health and safety (or prevention), compensation, rehabilitation and assessment.

The policies of the Board of Directors consist of:

(a) The statements contained under the heading "Policy" in the *Assessment Manual,*
(b) The statements contained under the heading "Policy" in the *Prevention Manual,*
(c) The *Rehabilitation Services & Claims Manual*, Volume I and Volume II, except statements under the "Background" heading, and the explanatory material at the end of each Item appearing in the new manual format,
(d) The *Classification and Rate List*, as approved annually by the Board of Directors,
(e) Decisions No. 1 – 423 in Volumes 1 – 6 *of the Workers' Compensation Reporter* prior to the date each Decision was retired from policy status,[1] and
(f) Policy decisions of the former Governors and the former Panel of Administrators still in effect immediately before February 11, 2003,

as well as amendments to policy in the four policy manuals, any new or replacement manuals issued by the Board of Directors, any documents published by the Workers' Compensation Board that are adopted by the Board of Directors as policies of the Board of Directors, and all decisions of the Board of Directors declared to be policy decisions.

The *Manual* in which this preface appears (*Rehabilitation Services & Claims Manual*, Volume II) contains current Board policy with respect to the rehabilitation and compensation matters described in Chapter 1 of the *Manual*. It is used by Board staff in carrying out their responsibilities under the *Workers Compensation Act*. As new policy is developed and approved in this area, the *Manual* will be updated by issuing replacement pages.

[1] All of Decisions No. 1 – 423 have been retired from policy status. An explanation of "retirement" and an index of retirement dates are found in APPENDIX 1 to this *Manual*.

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RE: Scope of Manual	ITEM: C1-1.00

BACKGROUND

1. Explanatory Notes

This policy provides an overview of the history and scope of the *Rehabilitation Services & Claims Manual*.

2. The Act

Section 229:

(1) In this section:

"former Act" means the *Workers Compensation Act*, R.S.B.C. 1996, c. 492;

"transition date" means June 30, 2002, being the date on which this section came into force.

(2) This section applies to an injury that occurred before the transition date.

(3) Subject to subsections (4) to (8), the former Act, as it read immediately before the transition date, applies to an injury that occurred before the transition date.

(4) Subject to subsections (5) to (8), if a worker's permanent disability first occurs on or after the transition date as a result of an injury that occurred before the transition date, this Act applies to the permanent disability.

(5) For the purposes of subsection (4), sections 194 to 196 *[compensation for permanent disability]* of this Act apply as if

(a) all references, other than references in section 196(3)(b)(i) *[permanent partial disability: exception to general rules]*, to "90%" were read as "75%",

(b) all references, other than references in section 196(3)(b)(i), to "average net earnings" were read as references to "average earnings determined under the former Act immediately before the transition date", and

(c) section 196(3)(b)(i) read as follows:

(i) the average earnings that the worker is earning after the injury, as determined under the former Act immediately before the transition date.

(6) Section 202 *[deductions in relation to Canada Pension Plan disability benefit]* does not apply in the circumstances described in subsection (4) of this section.

(7) Section 334 *[annual adjustment of periodic payment amounts]* applies to compensation paid to a worker on or after December 31, 2003, being the date on which section 228(5) came into force, irrespective of the date the worker was injured.

(8) If a worker has, on or after the transition date, a recurrence of a disability that results from an injury that occurred before the transition date, the Board must determine compensation for the recurrence based on this Act.

POLICY

A. INTRODUCTION

In 2002, the *Workers Compensation Act* underwent significant legislative amendment. This resulted in the restructuring of the *Rehabilitation Services & Claims Manual* into two volumes – Volume I and Volume II. This policy sets out an overview of the legislative changes and explains how readers of this *Manual* can determine which volume is applicable to their particular circumstances.

B. LEGISLATIVE AMENDMENTS

i. *Workers Compensation Amendment Act, 2002* ("*Amendment Act, 2002*")

The *Amendment Act, 2002* is also referred to as "Bill 49". It primarily amended the *Act*:

- effective June 30, 2002 in relation to compensation for injured workers (including the calculation of average net earnings, duration of wage-loss benefits, integration of CPP disability benefits, indexing of compensation benefits, worker obligations to provide information, mental stress and permanent disability benefits); and

- effective January 2, 2003 in relation to the establishment of a new board of directors as the governing body of the Workers' Compensation Board.

ii. *Workers Compensation Amendment Act (No. 2), 2002* ("*Amendment Act (No. 2), 2002*")

The *Amendment Act (No. 2), 2002* is also referred to as "Bill 63". It primarily amended the *Act* effective March 3, 2003 in relation to a new review/appeal structure and to the Board's authority to reopen matters previously decided or to reconsider previous decisions.

iii. *Skills Development and Labour Statutes Amendments Act, 2003* ("*Amendment Act, 2003*")

The *Amendment Act, 2003* is also referred to as "Bill 37". It primarily amended the *Act*:

- effective June 30, 2002 in relation to compensation payable as the result of the death of a worker (including the age of dependent children, the definition and integration of federal benefits and the calculation of benefits for childless spouses, for separated spouses and for dependants following the death of more than one worker); and

- effective December 31, 2003 in relation to the indexing of benefits payable as the result of the death of a worker, a psychologist's diagnosis of a worker's mental stress condition and lay advocates who provide assistance in workers' compensation matters.

C. SCOPE OF VOLUME I AND VOLUME II OF THIS MANUAL

The *Rehabilitation Services & Claims Manual* was restructured into two volumes to facilitate the implementation of the new compensation policies resulting from the *Amendment Act, 2002*. The new policies were incorporated into Volume II, and the policies in place immediately prior to June 30, 2002 became Volume I. (For policies in effect prior to the Volume I policies, readers are referred to the Board's archives.)

Volume I and Volume II apply to different categories of injured workers and surviving dependants. Whether the compensation for an injured worker is to be determined under the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as it read immediately before June 30, 2002, and administered under the corresponding policies under Volume I, depends on the transitional rules set out in section 229 of the *Act*. These are explained in Section D of this Item below. It is the responsibility of decision-makers to determine whether Volume I or Volume II applies to each case before them. In terms of compensation for the surviving dependants of a deceased worker, the policies in Volume II apply where the worker's death occurred on or after June 30, 2002.

Due to the fact that Volume I covers a finite group of injured workers and surviving dependants, its relevance to the workers' compensation system will gradually decrease over time. It is anticipated that there will be very few future amendments to the policies

in Volume I. Any major amendments will be listed, for convenience, in the Addendum to Chapter 1 in Volume I.

Volume II is used to administer claims for injuries and deaths occurring on or after June 30, 2002. Its relevance to the workers' compensation system will therefore continue over time. Volume II policies will be subject to amendment from time to time, in the same manner as policies in other policy manuals. Amendments to policies in Volume II will be archived in the Board's records and documented publicly.

D. SCOPE OF VOLUMES I AND II IN RELATION TO COMPENSATION FOR INJURED WORKERS

i. General

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

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

Unless otherwise stated, in Volume II of this *Manual* the "*Act*" refers to the *Workers Compensation Act*, R.S.B.C. 2019, c. 1, which includes amendments made on or after June 30, 2002. The *Interpretation Act*, R.S.B.C. 1996, c. 238, applies to the *Act*, unless a contrary intention appears in either the *Interpretation Act* or the *Act*.

ii. *Amendment Act, 2002* (Bill 49) Transitional Provisions

The following rules apply to determining whether the former provisions (Volume I) or the current provisions (Volume II) apply in a particular case. These rules are based on the transitional rules in section 229 of the *Act*.

1. The current provisions apply to an injury that occurs on or after June 30, 2002.

2. Except as noted in rules 3, 4, and 5, the former provisions apply to an injury that occurred before June 30, 2002.

3. Subject to rule 4 respecting recurrences, if an injury occurred before June 30, 2002, but the first indication that it is permanently disabling occurs on or after June 30, 2002, the current provisions apply to permanent disability benefits with two modifications:

(i) 75% of average earnings (former provisions) is used for calculating the amount of compensation rather than 90% of average net earnings (current provisions); and

(ii) no deduction is made for disability benefits under the Canada Pension Plan (former provisions).

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

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

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

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

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

The following are examples of a recurrence:

- A worker totally recovers from a temporary disability resulting in the termination of wage-loss benefits. Subsequently, there is a recurrence of the disability and the claim is re-opened for compensation.

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

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

E. STATUTE REVISION 2019

In 2019, pursuant to the *Statute Revision Act*, R.S.B.C. 1996, c. 440, the *Workers Compensation Act*, R.S.B.C. 2019, c. 1 was revised and ordered to come into effect on April 6, 2020. As a result of the revision, necessary consequential changes were made to Volume II:

- minor language clarifications, to mirror the Legislature's intent;
- mirroring the rewritten provisions' clarity, consistency, and gender-neutral style; and
- reflecting all the revised section numbers, and reorganization of parts, divisions, and sections.

The *Statute Revision Act* does not authorize legislative counsel to make substantive changes to the law. As such, a revision does not operate as new law but has effect and must be interpreted as a consolidation of the law contained in the *Act* and provisions replaced by the revision.

EFFECTIVE DATE:	Section D is effective August 1, 2006. Section E is effective April 6, 2020.
AUTHORITY:	Section 229 of the *Act*. Section 8 of the *Statute Revision Act*.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #1.00, #1.01, #1.02, #1.03, and #1.04, consequential to reformatting and renumbering policies in Chapter 1, *Scope of Volume II of this Manual*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. Former policy item #1.04 created to explain consequential revisions to Volumes I and II of the *Rehabilitation Services & Claims Manual* required to implement the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

August 1, 2006 – Former policy item #1.03 amended to clarify that then section 35.1(8) of the then *Act* does not apply to permanent changes in the nature and degree of a worker's permanent disability, and that for the purposes of this policy, a recurrence includes any claim that is reopened for an additional period of temporary disability, regardless of whether the worker had been entitled to permanent disability benefits before June 30, 2002.
December 31, 2003 – Amended to reflect consequential changes to the *Act* resulting from the *Skills Development and Labour Statutes Amendment Act, 2003* (Bill 37 of 2003).
June 17, 2003 – Reorganized the format and added content to address the scope of Volumes I and II of the *Manual*.
October 16, 2002 – Former policy item #1.03 amended to clarify meaning of "recurrence" for the purposes of then section 35.1(8) of the *Act*.

APPLICATION: Section D applies to all decisions, including appellate decisions, made on or after October 16, 2002.
Section E applies to all decisions, including appellate decisions, made on or after April 6, 2020.

RE: Compensation under the *Act* **ITEM: C1-1.10**

BACKGROUND

1. Explanatory Notes

This policy provides an overview of the types of compensation provided and the persons covered under the *Act*, along with references to associated chapters of this *Manual*.

2. The Act

None.

POLICY

A. PERSONS COVERED BY THE *ACT*

Not everyone is entitled to compensation under the *Act*, even if injured at work. To qualify for compensation, a person must be a "worker" employed by an employer covered by the *Act*. (See Chapter 2.) If a compensable injury or disease results in the worker's death, certain of the worker's relatives are entitled, but they must usually have been "dependants" during the worker's lifetime. (See Chapter 8.)

B. CONDITIONS UNDER WHICH COMPENSATION IS PAYABLE

Not all injuries or diseases are compensable. The *Act* prescribes the type of injuries (see Chapter 3) and diseases (see Chapter 4) and the circumstances in which they are compensable. (See Chapters 3 and 4.) Thus, for example, in the case of injuries, compensation is limited to personal injuries arising out of and in the course of a worker's employment.

C. TYPE AND AMOUNT OF COMPENSATION

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

1. payments to compensate the injured worker for loss of earnings caused by a temporary disability (see Chapter 5);

2. payments to a worker where the employer has failed to comply with the obligations under the duty to maintain employment (see Chapter 5);

3. payments to compensate permanent disability that results from a worker's injury, for actual or estimated permanent loss of earnings (see Chapter 6);

4. compensation to dependants for loss of support by a deceased worker (see Chapter 8);

5. health care benefits (see Chapter 10); and

6. vocational rehabilitation assistance (see Chapter 11).

D. CHARGING OF CLAIMS COSTS

The costs of compensation are normally charged to the employer rate group to which the worker's employer belongs. The costs may also affect the employer's experience rating. There are special provisions which relieve the rate group and/or the employer in certain situations. (See Chapter 17.)

EFFECTIVE DATE: Section C is effective January 1, 2024.

HISTORY: December 1, 2025 – This policy resulted from the consolidation of former policy items #1.10, #1.20, #1.30, and #1.40, consequential to reformatting and renumbering policies in Chapter 1, *Scope of Volume II of this Manual*.
January 1, 2024 – Policy changes made consequential to implementing Division 3.1 of the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41).
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

APPLICATION: Section C applies to all decisions made on or after January 1, 2024.

RE: Workers' Compensation Board	ITEM: C1-2.00

BACKGROUND

1. Explanatory Notes

This policy provides an overview of the jurisdiction of the Board, the responsibilities of the board of directors, and the application of the *Act* and policies to the adjudication of claims.

2. The Act

Section 1, in part:

> …
>
> **"Board"** means the Workers' Compensation Board continued under section 316 *[Workers' Compensation Board and its board of directors]*;
>
> …

Section 122(1):

> Subject to sections 288 and 289 *[appeals to appeal tribunal]*, the Board has exclusive jurisdiction to inquire into, hear and determine all matters and questions of fact and law arising or required to be determined under the compensation provisions, 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.

Section 316:

> (1) The Workers' Compensation Board is continued as a corporation.
>
> (2) The board of directors of the Workers' Compensation Board consists of
>
> (a) 9 voting directors appointed by the Lieutenant Governor in Council in accordance with section 317, and
>
> (b) the president appointed by the board of directors under section 323, who is a non-voting director.

Section 319:

The board of directors must set and revise as necessary the policies of the board of directors, including policies respecting occupational health and safety, compensation, rehabilitation and assessment.

Section 320:

(1) The board of directors must set and supervise the direction of the Board.

(2) Without restricting subsection (1), the board of directors is responsible for the following:

(a) subject to this Act, selecting the president and determining the president's functions;

(b) approving the operating and capital budgets of the Board;

(c) establishing policies and accounting systems to ensure adequate funding of the accident fund;

(d) approving major programs and expenditures of the Board;

(e) approving the investment of funds of the Board in accordance with the requirements imposed under this Act;

(f) planning for the future of the Board;

(g) subject to this Act, enacting bylaws and passing resolutions

(i) for the conduct of the business of the Board, and

(ii) for the functions of the board of directors,

including enacting bylaws respecting the manner in which the policies of the board of directors are to be published.

(3) The board of directors may establish committees and give directions to those committees.

(4) The board of directors may authorize the Board to acquire and dispose of land.

Section 339(2):

> The Board must make its decision based on the merits and justice of the case, but in doing this the Board must apply the policies of the board of directors that are applicable in that case.

POLICY

A. WORKERS' COMPENSATION BOARD

Section 316 of the *Act* provides that the Workers' Compensation Board is a corporation continued under the *Act* to administer the provisions of the *Act*. Section 1 defines the word "Board" as the Workers' Compensation Board. The use of the word "Board" throughout this *Manual* means the Workers' Compensation Board.

Section 319 provides that the board of directors must set and revise as necessary the policies of the board of directors, including policies respecting occupational health and safety, compensation, rehabilitation and assessment.

Section 320 provides that the board of directors must set and supervise the direction of the Board.

B. JURISDICTION OVER CLAIMS ADJUDICATION

Section 122(1) of the *Act* provides that the Board has exclusive jurisdiction to inquire into, hear and determine all matters and questions of fact and law arising or required to be determined under the compensation provisions of the *Act*, 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. Thus, the Board has sole jurisdiction over the adjudication of claims for compensation under the *Act*.

C. APPLICATION OF THE *ACT* AND POLICIES

In making decisions, the Board must take into consideration:

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

By considering the relevant provisions of the *Act*, the relevant policies, and the relevant facts and circumstances, the Board ensures that:

1. similar cases are adjudicated in a similar manner;

2. each participant in the system is treated fairly; and

3. the decision-making process is consistent and reliable.

Section 339(2) of the *Act* requires the Board to make all its decisions based on the merits and justice of the case. In making decisions, the Board must take into account all relevant facts and circumstances relating to the case before it, including the worker's individual circumstances. This is required, among other reasons, in order to comply with section 339(2). In doing so, the Board must consider the relevant provisions of the *Act.* If there are specific directions in the *Act* that are relevant to those facts and circumstances, the Board is legally bound to follow them.

Section 339(2) also requires the Board to apply the policies of the board of directors that are applicable to the case before it. The policies reflect the obligations and discretion delegated to the Board under the *Act.* Each policy creates a framework that assists and directs the Board in its decision-making role when certain facts and circumstances come before it. If such facts and circumstances arise and there is an applicable policy, the policy must be applied. Where the *Act* and policy provide for Board discretion, the Board is also required to exercise the discretion based upon the merits and justice of the case, in accordance with the *Act* and applicable policy.

All substantive and associated practice components in the policies in this *Manual* are applicable under section 339(2) and must be applied in decision-making. The term "associated practice components" for this purpose refers to the steps outlined in the policies that must be taken to determine the substance of decisions. Without these steps being taken, the substantive decision required by the *Act* and policies could not be made.

References to business processes that appear in policies are only applicable under section 339(2) in decision-making to the extent that they are necessary to comply with the rules of natural justice and procedural fairness. The term "business processes" for this purpose refers to the manner in which the Board conducts its operations. These business processes are not intrinsic to the substantive decisions required by the *Act* and the policies.

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

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

EFFECTIVE DATE:	Sections A and B are effective February 11, 2003. Section C is effective July 1, 2019.
AUTHORITY:	Sections 1, 122, 316, 319, 320, and 339 of the *Act*.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #2.00, #2.10, and #2.20, consequential to reformatting and renumbering policies in Chapter 1, *Scope of Volume II of this Manual*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. July 1, 2019 – Amended to emphasize the obligation of the Board to base its decisions upon the merits and justice of the case. June 1, 2009 – Deleted references to Board officers. March 3, 2003 – Amended to reflect the obligation of the Board in decision-making to apply a policy of the board of directors that is applicable to the case before it. February 11, 2003 – Deleted references to the Appeal Division and the former Governors.
APPLICATION:	Section C applies to decisions made on or after July 1, 2019.

RE: Coverage for Workers and Employers **ITEM: C2-3.00**

BACKGROUND

1. Explanatory Notes

This policy provides an overview of coverage for workers and employers under the compensation provisions of the *Act*, as well as applicable exemptions and exclusions.

2. The Act

Section 4(1):

> The compensation provisions apply to
>
> (a) all employers, in their capacity as employers, in British Columbia, and
>
> (b) all workers in British Columbia,
>
> other than employers or workers exempted by order of the Board.

POLICY

A. INTRODUCTION

The employers and workers who are covered and those who are exempted are the subject of this chapter of the *Manual*.

The *Act* does not apply to workers of the Federal Government of Canada. However, by section 4(2) of the *Government Employees Compensation Act*, an "employee" who is usually employed in British Columbia is given the same rights to compensation as workers under the British Columbia *Act*. The persons considered "employees" are dealt with in this chapter.

B. EXEMPTIONS AND EXCLUSIONS FROM COVERAGE

The criteria for the exemption of employers or workers may be found in policy in Item AP1-4-1 of the *Assessment Manual* along with general exemptions which are described in detail. The policy in Item AP1-4-1 also recognizes that some workers and employers are excluded from coverage under the *Act* as a matter of constitutional law or because they have no attachment to British Columbia industry.

C. COVERAGE OF WORKERS

It is a well established principle of workers' compensation that where an employer comes within the scope of the *Act*, all workers of that employer are covered for compensation. The coverage is not limited to those engaged in the manual part of the operation. Thus, in a wholesale establishment, for example, workers' compensation coverage extends to clerical and bookkeeping staff, and to corporate presidents, as well as those engaged in the receiving, handling, storage and transmission of goods. All of these functions are part of wholesaling. This position is not changed where an employer divides up the manual and clerical parts of its operation and attaches a separate corporate identity to each. Nor does it depend on whether the clerical and manual staff are employed by affiliated corporations. The result would be the same if there were no corporate affiliation.

A worker's claim is not prejudiced by the fact that the employer has not complied with the obligation to register with the Board. This is subject to the principles set out in the policy in Item AP1-1-1 of the *Assessment Manual*.

EFFECTIVE DATE:	Section B is effective February 11, 2003. Section C is effective January 1, 2023.
AUTHORITY:	Section 4 of the *Act*.
CROSS REFERENCES:	Item AP1-1-1, *Coverage under Act – Determining Workplace Status*; Item AP1-4-1, *Exemptions from Coverage*, of the *Assessment Manual*.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #3.00, #4.00, and #5.00, consequential to reformatting and renumbering policies in Chapter 2, *Workers and Employers Covered by the Act*. January 1, 2023 – Consequential changes related to the consolidation of policies on determining workplace status were made effective. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. March 18, 2003 – Policy revised as to numerical reference to the policy in the *Assessment Manual*. February 11, 2003 – Policy revised as to deletion of references to the former Governors.
APPLICATION:	Section C applies to all decisions made on or after January 1, 2023.

RE: Definitions of "Worker" and "Employer" **ITEM: C2-4.00**

BACKGROUND

1. Explanatory Notes

This policy provides an overview of the definitions of "worker" and "employer" under the *Act*.

2. The Act

Section 1, in part:

> **"employer"** includes every person having in their service under a contract of hiring or apprenticeship, whether the contract is written or oral, express or implied, a person engaged in work in or about an industry;
>
> …
>
> **"online platform worker"** means a person who performs prescribed work that the person accepts through an online platform;
>
> …
>
> **"worker"** includes the following:
>
> (a) a person who has entered into or works under a contract of service or apprenticeship, whether the contract is written or oral, express or implied, and whether by way of manual labour or otherwise;
>
> (b) a person who
>
> (i) is a learner who is not under a contract of service or apprenticeship, and
>
> (ii) becomes subject to the hazards of an industry within the scope of the compensation provisions for the purpose of undergoing training or probationary work specified by the employer as a preliminary to employment;
>
> (c) a firefighter;

(d) in respect of the industry of mining, a person

(i) while the person is actually engaged in taking or attending a course of training or instruction in mine rescue work under the direction or with the written approval of an employer in whose employment that person is employed as a worker in that industry,

(ii) while, with the knowledge and consent of an employer in that industry, either express or implied, the person is actually engaged in rescuing or protecting, or attempting to rescue or protect, life or property in the case of an explosion or accident that endangers either life or property in a mine, whether or not during the time that person is so engaged the person is entitled to receive wages from the employer, or from any employer, or is performing the work or service as a volunteer, or

(iii) while the person is engaged as a member of the inspection committee, appointed or elected by the workers in the mine, to inspect the mine on behalf of the workers;

(e) an independent operator to whom the compensation provisions apply by the Board direction under section 4(2)(a) *[extending application: independent operator who is neither an employer nor a worker]*;

(f) a person deemed by the Board to be a worker under section 6(2) *[extending application: vocational or training programs]*;

…

Section 1.1:

For the purposes of this Act,

(a) an online platform worker is to be considered a worker, whether or not the online platform worker is a worker or employee under any law, and

(b) the operator of the online platform through which an online platform worker accepts prescribed work is to be considered the employer of the online platform worker.

3. Online Platform Workers Regulation

Section 1:

In this regulation:

"Act" means the *Workers Compensation Act*;

"applicable online order" means an order placed and paid for by means of a delivery services online platform if the following conditions are satisfied:

(a) the order is for one or more delivery service items;

(b) a delivery services worker

(i) picks up the delivery service item from the person who is the seller of the item, and

(ii) delivers the delivery service item to

(A) the person who placed and paid for the order, or

(B) a person specified by the person who placed and paid for the order;

(c) the seller referred to in paragraph (b)(i) is not a platform operator or platform operator affiliate;

"delivery service item" means the following:

(a) prepared food;

(b) a beverage;

(c) a good, including a grocery item;

"delivery services online platform" means an online platform that connects delivery services workers with persons who require the services of those workers;

"delivery services worker" means an online platform worker who performs work described in section 2(a);

"platform operator" means a person who operates a delivery services online platform or a ride-hail online platform;

"platform operator affiliate" means an affiliate, as defined in the *Business Corporations Act*, of a platform operator;

"ride-hail online platform" means an online platform that connects ride-hail services workers with persons who require the services of those workers;

"ride-hail services worker" means an online platform worker who performs work described in section 2(b).

Section 2:

For the purposes of the definition of "online platform worker" and section 1.1(b) of the Act, the following work is prescribed:

(a) work performed for the purpose of picking up and delivering an applicable online order;

(b) work performed for the purpose of transporting one or more passengers whose transportation is ordered through a ride-hail online platform.

POLICY

A. DEFINITIONS OF "WORKER" AND "EMPLOYER"

The basic definitions of "worker" and "employer" in section 1 of the *Act* are as follows:

"Employer" includes every person having in their service under a contract of hiring or apprenticeship, whether the contract is written or oral, express or implied, a person engaged in work in or about an industry;

"Worker" includes the following:

(a) a person who has entered into or works under a contract of service or apprenticeship, whether the contract is written or oral, express or implied, and whether by way of manual labour or otherwise;

Detailed discussions concerning the definitions of worker and employer may be found in the policy in Item AP1-1-1 of the *Assessment Manual*.

B. NATURE OF EMPLOYMENT RELATIONSHIP

Where a person contracts with another to provide labour in an industry covered by the *Act*, the Board considers that the contract may create one of two types of relationship.

The persons doing the work may be independent operators, or workers. Very detailed registration rules concerning independent operators and workers are outlined in the policy in Item AP1-1-1 of the *Assessment Manual*.

C. VOLUNTARY AND OTHER WORKERS WHO RECEIVE NO PAY

Usually a "worker" is paid. Therefore, it is not surprising that voluntary or other workers receiving no payment for their work are not generally considered workers under the *Act*. On the other hand, some workers of this type are expressly included within the scope of the *Act*, and the Board is given express power to admit others at its discretion. Furthermore, the receipt of some sort of payment by such workers may lead to their being workers under the *Act*. Further information about volunteers can be found in the policies in Items AP1-1-1 and AP1-5/6/7-1 of the *Assessment Manual*.

D. SPECIFIC INCLUSIONS IN DEFINITION OF WORKER

Section 1 includes within the *Act's* basic definition of "worker" certain classes of people who might otherwise not be covered. Those classes of people are discussed in detail in the policies in Items AP1-1-1 and AP8-336-1 of the *Assessment Manual*.

EFFECTIVE DATE:	January 1, 2023
AUTHORITY:	Sections 1 and 1.1 of the *Act*.
CROSS REFERENCES:	Item C2-4.10, *Coverage for Volunteer Firefighters*, of the *Rehabilitation Services & Claims Manual*, Volume II. Item AP1-1-1, *Coverage under Act – Determining Workplace Status*; Item AP1-5/6/7-1, *Extending Application of the Act*; Item AP8-336-1, *Coverage under Federal Statutes or Agreements Between the Provincial and Federal Governments*, of the *Assessment Manual*.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #6.00, #6.10, #6.20, and #7.00, consequential to reformatting and renumbering policies in Chapter 2, *Workers and Employers Covered by the Act*. Housekeeping amendments to reflect legislative provisions added by the *Labour Statutes Amendment Act, 2023* (Bill 48), and the *Online Platform Workers Regulation*. January 1, 2023 – Consequential changes related to the consolidation of policies on determining workplace status were made effective. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. March 18, 2003 – Policy revised as to numerical reference to the policy in the *Assessment Manual*.
APPLICATION:	Applies to all decisions made on or after January 1, 2023.

RE: Coverage for Volunteer Firefighters **ITEM: C2-4.10**

BACKGROUND

1. Explanatory Notes

This policy sets out the definition of "firefighter" under the *Act* and provides guidance on coverage for volunteer firefighters.

2. The Act

Section 1, in part:

> **"firefighter"** means a member of a fire brigade, working with or without remuneration, who is assigned primarily to
>
> (a) fire suppression duties, whether or not those duties include the performance of ambulance or rescue services,
>
> (b) investigation duties respecting the cause, origin or circumstances of a fire, or
>
> (c) any combination of both fire suppression duties as described in paragraph (a) and fire investigation duties as described in paragraph (b);
>
> …
>
> **"worker"** includes the following:
>
> …
>
> (c) a firefighter;
>
> …

POLICY

Volunteer firefighters are given coverage by the definitions of "firefighter" and "worker" under section 1 of the *Act*.

A volunteer firefighter may also include an individual at the scene of a fire, who is requested to assist by the Fire Chief, or authorized designate, and whose name is recorded. Only those individuals under the direction and control of the Fire Chief or authorized designate are covered.

A volunteer firefighter may be entitled to compensation for injuries, mental disorders, or death arising out of and in the course of the activities of the fire department.

A. TRAVEL

Volunteer firefighters are not covered for injuries, mental disorders, or death which occur while routinely commuting to and from the fire department.

A volunteer firefighter's travel may be considered part of the activities of the fire department when:

- in response to an emergency call out, the volunteer firefighter is directed by the Fire Chief or authorized designate, to travel to the fire hall, a fire or other site of emergency; and
- while returning to the volunteer's home or regular job after attending to the emergency duties, via the most direct route without departure for personal reasons.

If the volunteer firefighter's injury, mental disorder, or death results primarily from the activity associated with the urgency of the preparation for travel, it may be considered to arise out of and in the course of the activities of the fire department, and therefore be compensable. This is an exception to the general rule that workers who are employed to travel are considered to be in the course of the employment only from the time the worker commences travel on the public roadway.

B. EMERGENCY RESPONSE DUTIES

In addition to fighting fires, a volunteer firefighter's duties may also include responding to various emergency situations such as:

- facilitating evacuations;
- performing rescues;
- controlling hazardous substances;
- providing traffic control;
- disaster planning/response; and

- other related duties assigned by the Fire Chief or designate.

C. PARTICIPATION IN PRACTICES AND DRILLS

An injury, mental disorder, or death that occurs during a volunteer firefighter's participation in practices or drills may be considered to arise out of and in the course of the activities of the fire department, if participation was undertaken at the direction of the Fire Chief or authorized designate, regardless of whether the practice or drill takes place at the fire hall or some off-site location.

Practices include training sessions that involve the teaching of vocational or practical skills specifically related to those used within the fire department, such as live firefighter training.

D. OTHER EMPLOYMENT ACTIVITIES

i. Maintenance Duties

An injury, mental disorder, or death that occurs during a volunteer firefighter's maintenance of the building or equipment within the environs of the fire hall may be considered to arise out of and in the course of the activities of the fire department, where the volunteer firefighter is authorized and under the direct supervision and control of the Fire Chief or authorized designate.

ii. Public Relations Activities

An injury, mental disorder, or death that occurs during a volunteer firefighter's participation in public relations activities may be considered to arise out of and in the course of the activities of the fire department.

Public relations activities may include participation in recruitment, charity drives and safety education.

Factors that may weigh in favour of coverage for injuries or death that occur during a volunteer firefighter's participation in public relations activities, include whether the participation:

- is for the benefit of the fire department;
- was undertaken at the direction of the Fire Chief or authorized designate;
- involved using equipment supplied by the fire department;
- was during a time when the fire department was operational; or
- was considered to be part of the volunteer firefighter's duties.

No single factor is determinative. The more tenuous the connection to the activities of the fire department, the less these factors favour coverage.

EFFECTIVE DATE:	October 1, 2007
AUTHORITY:	Sections 1 and 4 of the *Act*.
CROSS-REFERENCE:	Item C3-14.00, *Arising Out of and in the Course of a Worker's Employment*; Item C3-19.00, *Work-Related Travel*; Item C3-21.00, *Extra-Employment Activities*; Item C3-24.00, *Section 135 – Mental Disorders*; Item C3-24.10, *Section 135(2) – Mental Disorder Presumption*; Item C4-25.20, *Establishing Work Causation* (Section A. Schedule 1 Presumption and Section B. Additional Presumptions in the Workers Compensation Act), of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from former policy item #7.10, consequential to reformatting and renumbering policies in Chapter 2, *Workers and Employers Covered by the Act*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. May 16, 2019 – The *Workers Compensation Amendment Act, 2019* (Bill 18 of 2019) added a definition of "firefighter" to section 1 of the *Act* and amended the definition of "worker". October 1, 2007 – This policy was amended to provide clarification on coverage for volunteer firefighters.
APPLICATION:	Applies to all injuries on or after October 1, 2007.

RE:	Admission of Workers, Employers, and Independent Operators	ITEM:	C2-5.00

BACKGROUND

1. Explanatory Notes

This policy provides an overview of the admission of workers, employers, and independent operators under the *Act*.

2. The Act

Section 4(2):

> The Board may direct that the compensation provisions apply on the terms specified in the Board's direction to
>
> (a) an independent operator who is neither an employer nor a worker as if the independent operator were a worker, or
>
> (b) an employer as if the employer were a worker.

Section 5:

> (1) In relation to a person or group of persons carrying on an undertaking that the Board considers is in the public interest, the Board may, on the terms and conditions the Board directs,
>
> (a) deem the person or group of persons, whether or not any of them receive payment for their services, to be a worker or workers for the purposes of this Act, and
>
> (b) on approval of the Lieutenant Governor in Council, deem the person or group of persons to be a worker or workers of the Crown in right of British Columbia.
>
> (2) Without limiting subsection (1), admissions under this section may be made at the time, in the manner, subject to the terms and conditions and for the period the Board considers adequate and proper.

Section 6:

(1) This section applies if the minister responsible for the *School Act* or the minister responsible for the *College and Institute Act*, as applicable, and the minister responsible for the administration of this Act approve

(a) a vocational or training program, and

(b) a school or other location as a place at which the vocational or training program is to be provided.

(2) The Board may, at the request of a minister referred to in subsection (1), deem a person or class of persons enrolled in a program approved under that subsection to be a worker or workers of the Crown in right of British Columbia.

(3) In relation to a person who is deemed to be a worker under subsection (2), compensation under this Act is payable under the compensation provisions for injuries to the worker arising out of and in the course of training for that worker.

(4) As limits on subsection (3), if an injury results in a period of temporary disability with no loss of earnings,

(a) subject to paragraph (b) of this subsection, a health care benefit only is payable, and

(b) if training allowances paid by Canada or British Columbia are suspended, the Board may, for the period the Board considers advisable, pay compensation in the amount of the training allowance.

(5) Admissions under this section may be made at the time, in the manner, subject to the terms and conditions and for the period the Board considers adequate and proper.

Section 7:

(1) This section applies in relation to a person or group of persons engaged in a work study program or other program of self-improvement involving work, whether or not the person or group of persons receives payment for the work.

(2) The Board may,

(a) on the application of an employer or a program organizer, and on the terms and conditions the Board directs, by order, admit the person or group of persons as being within the scope of the compensation provisions, and

(b) with the approval of the Lieutenant Governor in Council, deem a person or group of persons engaged in the program to be a worker or workers of the Crown in right of British Columbia, on the terms and conditions the Board determines.

(3) Without limiting subsection (2), admissions under this section may be made at the time, in the manner, subject to the terms and conditions and for the period the Board considers adequate and proper.

(4) On admission under subsection (2)(a),

(a) the person or group of persons is deemed to be a worker or workers to whom the compensation provisions apply, and

(b) the Board may levy assessments on the applicable employer or program organizer by the formula the Board determines.

POLICY

A. GENERAL

The *Act* contains powers to admit workers, employers and independent operators.

A discussion of the situations where coverage may be extended under sections 4, 5, 6 and 7 of the *Act* is found in the policies in Items AP1-1-1, AP1-4-2, AP1-4-3 and AP1-5/6/7-1 of the *Assessment Manual*.

B. ADMISSION OF FEDERAL GOVERNMENT EMPLOYEES

The *Government Employees Compensation Act* ("*GECA*") grants "employees" of the Federal Government usually employed in the province the same rights to compensation as non-Federal employees. The definition of "employee" is given in section 2 of the *GECA*, and takes the form of five alternative definitions which are as follows:

"(a) any person in the service of Her Majesty who is paid a direct wage or salary by or on behalf of Her Majesty,

(b) any member, officer or employee of any department, corporation or other body that is established to perform a function or duty on the Government of Canada's behalf who is declared by the Minister with the approval of the Governor in Council to be an employee for the purposes of this *Act*,

(c) any person who, for the purpose of obtaining employment in any department, corporation or other body that is established to perform a function or duty on the Government of Canada's behalf, is taking a training course that is approved by the Minister for that person,

(d) any person who is employed by any department, corporation or other body that is established to perform a function or duty on the Government of Canada's behalf, who is on leave of absence without pay and, for the purpose of increasing the skills used in the performance of their duties, is taking a training course that is approved by the Minister for that purpose, and

(e) any officer or employee of the Senate, House of Commons, Library of Parliament, office of the Senate Ethics Officer, office of the Conflict of Interest and Ethics Commissioner, Parliamentary Protective Service or office of the Parliamentary Budget Officer;".

This definition is wide enough to cover most Federal employees, whether employed directly by the Government or by some statutory body. For example, it covers post office workers. The definition also includes certain persons taking training courses relating to their employment with the Government.

Any person appointed by authority of the Chief Electoral Officer and the *Canada Election Act* to prepare for and hold a Federal election is considered as an employee of the Federal Government for the purposes of the *GECA*. This definition includes Returning Officers, Election Clerks, Enumerators, Stenographers, Typists, Poll Clerks and a Constable.

Effective November 10, 1976, employees of the Bank of Canada are considered employees under the *GECA*.

EFFECTIVE DATE:	Section A is effective January 1, 2023.
AUTHORITY:	Sections 4, 5, 6, and 7 of the *Act*.
CROSS REFERENCES:	Item AP1-1-1, *Coverage under Act – Determining Workplace Status*; Item AP1-4-2, *Requesting a Variance from a General Exemption*; Item AP1-4-3, *Personal Coverage*; Item AP1-5/6/7-1, *Extending Application of the Act*, of the *Assessment Manual*.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #8.00 and #8.10, consequential to reformatting and

renumbering policies in Chapter 2, *Workers and Employers Covered by the Act*.
January 1, 2023 – Consequential changes related to the consolidation of policies on determining workplace status were made effective.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
March 18, 2003 – Policy revised as to numerical reference to the policy in the *Assessment Manual*.

APPLICATION: Section A applies to all decisions made on or after January 1, 2023.

RE: Personal Injury **ITEM: C3-12.00**

BACKGROUND

1. Explanatory Notes

This policy defines "personal injury", distinguishing it from occupational disease.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

POLICY

Compensation is paid where a personal injury or death arising out of and in the course of a worker's employment is caused to the worker.

A. Definition of Personal Injury

"Personal injury" is defined as any physiological change resulting from some cause. It may result from a specific incident or a series of incidents occurring over a period of time.

Personal injury is not confined to injuries which are readily and objectively verifiable by their outward signs, e.g., breaks in the skin, swelling, discolouration, deformity, etc. It includes, for example:

- strains and sprains;
- damage to dental crowns and fixed bridgework, as they are regarded as parts of the anatomy, rather than as artificial appliances or dentures. For this reason, such claims are adjudicated under section 134(1) rather than under section 161(1);
- psychological impairment. Conditions of this type may be a compensable consequence of an accepted personal injury or occupational disease (see Item C3-22.30); and

- aggravations of a pre-existing non-compensable disease that are attributable to a specific event or trauma, or to a series of specific events or traumas (see Section C. of Item C4-25.20).

Apart from personal injury, the Board is authorized:

(1) by section 135, to compensate a worker for a mental disorder that does not result from an injury for which the worker is otherwise entitled to compensation, (see Items C3-24.00 and C3-24.10);

(2) by section 136, to compensate a worker for an occupational disease, (see Chapter 4); and

(3) by section 161(1), to replace or repair workers' artificial appliances, eyeglasses, dentures and hearing aids damaged or broken at work. (See Item C3-23.00).

B. Non-Occurrence of a Specific Incident

As noted above, it is not a bar to compensation if an injury results from a series of incidents occurring over a period of time rather than from a specific incident. It is also not a bar to compensation if an injury results from work activities to which the worker is accustomed and has previously performed without injury. The Board should examine the details of how the work activity was performed. To be compensable as an injury the evidence must warrant a conclusion that there was something in the employment that had causative significance in producing the injury. A speculative possibility that this might be so is not enough.

This does not mean that the presence or absence of a specific incident is never relevant in the decision of a claim for compensation. The etiology of a disabling condition is always relevant, and the presence or absence of a specific incident may have some evidentiary value in establishing whether it was employment-related. As well, there are some disabilities that are classified as resulting from an "injury" if they result from a specific incident, but are classified as resulting from a "disease" if they result from a series of incidents occurring over a period of time. The absence of a specific incident may mean that the worker has a disease rather than a personal injury.

C. Distinction Between an Injury and Disease

It is important to distinguish between an injury and a disease, because the *Act* creates different criteria to be met before compensation is provided for each. Compensation for occupational disease is discussed in Chapter 4.

The following are examples of personal injuries:

1. Wounds.
2. Fractures.
3. Concussions.
4. Physiological changes caused by explosion.
5. Sprains and strains.
6. Damaged cartilage or ligaments.
7. Dislocation of the bones at a joint.
8. Burns caused by a single incident of a chemical spilled on the skin.

The following are examples of diseases:

1. A disability caused by the gradual absorption of a chemical through the skin, by inhalation, or otherwise.

2. Cancer.

3. Respiratory disease such as asbestosis.

4. Contagious disease such as tuberculosis.

The following are examples of physiological changes that can be classified as either an injury or a disease, depending on the circumstances:

1. Infections. An infection incidental to a compensable injury is treated as part of the injury, otherwise it is classified as a disease.

2. Hearing loss. Hearing loss that results from an explosion is classified as an injury. Hearing loss that results from exposure to noise over a period of time or by infection is classified as a disease.

3. Disablement from Vibrations

   a) Instant disablement of a worker that results from vibrations of a traumatic nature, such as an explosion, is classified as an injury.

   b) Instant disablement of a worker, for example some sudden breakdown in the worker's system, that results from exposure to vibrations over a period of time, is classified as an injury.

   c) A gradual deterioration in a worker's condition that results from exposure to vibrations over a period of time is classified as a disease.

4. Heart Conditions

a) Physiological changes of the heart attributed to a specific event or cause, or to a series of specific events or causes are classified as injuries.

b) Physiological changes of the heart involving a gradual onset and not attributed to a specific event or cause, or to a series of specific events or causes, are classified as diseases.

EFFECTIVE DATE:	February 15, 2021
AUTHORITY:	Section 134(1) of the *Act.*
CROSS REFERENCES:	Item C3-22.30, *Compensable Consequences – Psychological Impairment*; Item C3-23.00, *Replacement and Repair of Personal Possessions – Section 161(1)*; Item C3-24.00, *Section 135 – Mental Disorders*; Item C3-24.10, *Section 135(2) – Mental Disorder Presumption*; Chapter 4, *Occupational Disease*; Item C4-25.10, *Has a Designated or Recognized Occupational Disease*, of the *Rehabilitation Services & Claims Manual*, Volume II. Schedule 1 of the *Act.*
HISTORY:	February 15, 2021 − Policy amended to provide guidance on injuries caused by overexertion during accustomed work. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. July 1, 2010 − This policy resulted from the consolidation of former policy items #12.00, #13.00, #13.10, #13.12, #13.20, and #14.20 of the *Rehabilitation Services & Claims Manual*, Volume II.
APPLICATION:	Applies to all decisions made on or after February 15, 2021, respecting claims for injuries occurring on or after July 1, 2010.

RE: Entitlement for Federal Government Employees **ITEM: C3-12.10**

BACKGROUND

1. Explanatory Notes

This policy outlines the test for entitlement to compensation for personal injury or death of federal government employees working in British Columbia.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

Section 336:

> The Board may exercise any power or duty conferred or imposed on it by or under a statute of Canada or agreement between Canada and British Columbia.

3. Government Employees Compensation Act

Section 3:

(1) This Act does not apply to any person who is a member of the regular force of the Canadian Forces or of the Royal Canadian Mounted Police.

(2) This Act applies in respect of an accident occurring or a disease contracted within or outside Canada.

Section 4, in part:

(1) Subject to this Act, compensation shall be paid to

(a) an employee who

(i) is caused personal injury by an accident arising out of and in the course of his employment, or

(ii) is disabled by reason of an industrial disease due to the nature of the employment; and

(b) the dependants of an employee whose death results from such an accident or industrial disease.

(2) The employee or the dependants referred to in subsection (1) are, notwithstanding the nature or class of the employment, entitled to receive compensation at the same rate and under the same conditions as are provided under the law of the province where the employee is usually employed respecting compensation for workmen and the dependants of deceased workmen, employed by persons other than Her Majesty, who

(a) are caused personal injuries in that province by accidents arising out of and in the course of their employment; or

(b) are disabled in that province by reason of industrial diseases due to the nature of their employment.

(3) Compensation under subsection (1) shall be determined by

(a) the same board, officers or authority as is or are established by the law of the province for determining compensation for workmen and dependants of deceased workmen employed by persons other than Her Majesty; or

(b) such other board, officers or authority, or such court, as the Governor in Council may direct.

...

Section 5:

(1) Where an employee is usually employed in Yukon or the Northwest Territories, the employee shall for the purposes of this Act be deemed to be usually employed in the Province of Alberta.

(2) Where an employee is usually employed in Nunavut, the employee shall for the purposes of this Act be deemed to be usually employed in the Province of Alberta.

Section 6:

> Where an employee, other than a person locally engaged outside Canada, is usually employed outside Canada, the employee shall for the purposes of this Act be deemed to be usually employed in the Province of Ontario.

POLICY

Compensation for personal injury or death arising out of and in the course of the employment of federal government employees is addressed in the *Government Employees Compensation Act* ("*GECA*").

The employees covered by the *GECA* are also discussed in Item C2-5.00.

The phrase "by an accident" in section 4(1) of the *GECA* does not require that there be a clearly ascertainable incident or series of incidents which caused the injury. Injuries that arise gradually over time or "by process" are not excluded by this subsection. The injury itself can be the "accident" for the purpose of section 4 of the *GECA*. Thus, the test for entitlement of federal employees in British Columbia under section 4(1) of the *GECA* is, in effect, the same as the test for entitlement for other workers in British Columbia under section 134(1) of the British Columbia *Act*.

Section 4(2) of the *GECA* provides that notwithstanding the nature or class of their employment, federal government employees, or their dependants, are entitled to receive compensation at the same rate and under the same conditions as are provided under the law of the province where the employee is usually employed. A federal government employee will be considered to be "usually employed" in British Columbia where appointed or engaged to work in British Columbia. In accordance with the *GECA*, federal government employees considered to be "usually employed" somewhere other than in British Columbia will not be covered by the British Columbia *Act*.

Section 3(2) of the *GECA* provides that the *GECA* applies to an accident occurring or a disease contracted within or outside Canada.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 134(1) of the *Act.*
CROSS REFERENCES:	Item C2-5.00, *Admission of Workers, Employers, and Independent Operators*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 − Housekeeping change to update internal cross-reference, consequential to reformatting and renumbering Chapter 2, *Workers and Employers Covered by the Act*.

April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
July 1, 2010 − The interpretation that the test for entitlement under section 4(1) of the *GECA* is equivalent to the test for entitlement under section 134(1) of the *Act* is based on Appeal Division Decision No. 92-0743.

APPLICATION: This item applies to all claims for injuries occurring on or after July 1, 2010.

RE: Commencement and Termination of the Employment Relationship **ITEM: C3-12.20**

BACKGROUND

1. Explanatory Notes

This policy provides guidance as to when the employment relationship commences and terminates for the purposes of determining whether a personal injury or death arises out of and in the course of a worker's employment.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

POLICY

The commencement and termination of an employment relationship for compensation purposes is not limited to the commencement or termination of a contract of service. A decision is made whether, having regard to the substance of the matter, an employment relationship had commenced or terminated for compensation purposes.

A person offering services to an employer will often be told to come back at a certain time in the future when work might be available. A person may also be promised a specific job but the commencement date may be specified some weeks or months ahead. Such persons would not normally become workers under the *Act* until they actually returned to the employer's premises at the future date for the commencement of work.

The fact that a worker has not commenced productive work is not a bar to compensation. For example, if an injury takes place while entering the employer's premises on the way to the first day of work, coverage may be extended before the necessary hiring formalities are complete or productive work commences.

Similarly, an employment relationship does not automatically terminate for compensation purposes when a contract of service is terminated by notice.

Workers may be eligible for compensation coverage for a reasonable period while winding up their affairs and leaving the employer's premises.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 134(1) of the *Act.*
CROSS REFERENCES:	Item C3-19.00, *Work-Related Travel* (Section B. Journeys to a Remote Worksite), of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. July 1, 2010 − This policy replaced policy items #17A.10 and #17A.20, of the *Rehabilitation Services & Claims Manual*, Volume II.
APPLICATION:	This item applies to all claims for injuries occurring on or after July 1, 2010.

RE: Infectious Agent or Disease Exposures **ITEM: C3-12.30**

BACKGROUND

1. Explanatory Notes

This policy provides guidance for determining a worker's entitlement to compensation following exposure to an infectious agent or disease.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

POLICY

A worker may be entitled to compensation in respect of an infectious agent or disease exposure where the exposure:

(a) occurs as a compensable consequence of a personal injury (e.g., where a rabid dog bites a veterinarian, breaking the veterinarian's skin, the exposure to rabies is a compensable consequence of the broken skin);

(b) has caused the onset of an occupational disease; or

(c) is accepted as compensable itself, in the absence of an objectively identifiable physical trauma, before conclusive evidence of the worker's infectious status is available (e.g., where exposure to an infectious disease with a long incubation period, such as HIV/AIDS or Hepatitis B, occurs as a result of infected bodily fluid splashing onto a worker's mucous membrane or non-intact skin).

An exposure, as described in (c) above, may be accepted as compensable itself, where the following four conditions are satisfied:

(i) there is objective evidence that the worker was exposed, or was very likely to have been exposed, to an infectious agent or disease;

(ii) the exposure arises out of and in the course of the worker's employment;

(iii) there is a moderate to high risk that, based on the mechanism and amount of exposure that occurred, the exposure will result in the worker developing a disease with health consequences that are so serious it may be life-threatening; and

(iv) the effects of the exposure can be significantly mitigated or prevented by the immediate provision of post-exposure prophylaxis ("PEP").

Medical evidence is required to assess the degree of risk and necessity of PEP on a case-by-case basis.

For example, a compensable exposure may result where a patient's blood splashes into the eyes of an attending nurse. If there is objective evidence that the nurse was exposed to an infectious disease such as HIV (e.g., if the patient is known to be HIV-positive), and if a physician concludes there is a moderate to high risk the nurse will develop HIV, a potentially life-threatening disease which cannot be immediately detected following exposure, and if PEP will mitigate or prevent the onset of HIV, the exposure can be accepted as compensable.

If a worker has an adverse reaction to PEP or develops a disease following a compensable exposure, entitlement in respect of the resultant injury, increased disablement, disease or death is adjudicated in accordance with Board policies on compensable consequences of employment-related injuries.

No compensation is payable to a worker who withdraws from work or changes employment because of concern that exposure to the conditions at work may cause an injury or disease which does not yet exist.

Wage-loss benefits are not payable to a worker who remains off work or who changes employment to prevent a reoccurrence of a personal injury or occupational disease that has resolved, or to prevent an aggravation, activation, or acceleration of a personal injury or occupational disease which has stabilized or plateaued. However, vocational rehabilitation assistance may be provided to a worker in this situation. Where the worker is left with a permanent impairment, the worker may be entitled to permanent disability benefits.

EFFECTIVE DATE: October 1, 2007
AUTHORITY: Section 134(1) of the *Act*.
CROSS REFERENCES: Item C3-16.10, *Pre-Existing Conditions – Specific Injuries*;
Item C3-22.00, *Compensable Consequences*;
Item C4-25.00, *Occupational Disease*;

Item C5-34.00, *Duration of Wage-Loss Benefits*;
Item C11-88.80, *Vocational Rehabilitation – Preventative Rehabilitation*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:

October 21, 2020 − Housekeeping amendments to the Cross-References to update policy title.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
This policy replaced former policy item #13.40 effective January 1, 2009 by putting it into the new policy format.
Policy item #13.40 was created and brought into effect on October 1, 2007 to replace former policy item #32.60 of the *Rehabilitation Services & Claims Manual*, Volume II.

APPLICATION:

To all infectious agent or disease exposures occurring on or after October 1, 2007.

RE: Arising Out of and In the Course of a Worker's Employment **ITEM: C3-14.00**

BACKGROUND

1. Explanatory Notes

This is the principal policy of this Chapter and sets out the decision-making principles for determining a worker's entitlement to compensation for personal injury or death under the *Act*.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

Section 339(3):

> If the Board is making a decision respecting the compensation or rehabilitation of a worker and the evidence supporting different findings on an issue is evenly weighted in that case, the Board must resolve that issue in a manner that favours the worker.

POLICY

The test for determining if a worker's personal injury or death is compensable, is whether it arises out of and in the course of the worker's employment. The two components of this test of employment connection are discussed below.

In applying the test of employment connection, it is important to note that employment is a broader concept than work and includes more than just productive work activity. An injury or death that occurs outside a worker's productive work activities may still arise out of and in the course of the worker's employment.

A. Meaning of "Arising Out of a Worker's Employment"

"Arising out of a worker's employment" generally refers to the cause of the injury or death. In considering causation, the focus is on whether the worker's employment was of causative significance in the occurrence of the injury or death.

Both employment and non-employment factors may contribute to the injury or death. The employment factors need not be the sole cause. However, in order for the injury or death to be compensable, the employment has to be of causative significance, which means more than a trivial or insignificant aspect of the injury or death.

B. Meaning of "In the Course of a Worker's Employment"

"In the course of a worker's employment" generally refers to whether the injury or death happened at a time and place and during an activity consistent with, and reasonably incidental to, the obligations and expectations of the worker's employment. Time and place are not strictly limited to the normal hours of work or the employer's premises.

C. Evidence

The Board considers both medical and non-medical evidence to determine whether a worker's injury or death arises out of and in the course of the worker's employment.

For decisions respecting the compensation or rehabilitation of a worker, the standard of proof under section 339(3) of the *Act*, is "at least as likely as not." If the evidence supporting different findings on an issue is evenly weighted, the issue is resolved in a manner that favours the worker.

This standard of proof is different than medical or scientific standards of certainty. Therefore, the presence or absence of expert evidence supporting or opposing a causal link is relevant and will generally be given weight by the Board, but it is not determinative of causation; causation can be inferred from other evidence. In every case, the Board decides whether the evidence supports a finding of causation based on a weighing of the evidence.

i. Medical

When reviewing medical evidence, the Board considers whether:

- there is a physiological association between the injury or death and the employment activity, including whether the activity was of sufficient degree and/or duration to be of causative significance in the injury or death;

- there is a temporal relationship between the work activity and the injury or death; and

- any non-work related medical conditions were a factor in the resulting injury or death.

The Board also considers any other relevant medical evidence to assist in determining whether a worker's injury or death arises out of and in the course of the worker's employment.

ii. Non-Medical

In addition to medical evidence, the Board considers the factors described below. All of the factors listed may be considered in making a decision, but no one of them may be used as an exclusive test for deciding whether an injury or death arises out of and in the course of the worker's employment. This list is by no means exhaustive, and relevant factors not listed in policy may also be considered.

Other policies in this Chapter may provide further guidance as to whether the injury or death arises out of and in the course of the worker's employment in particular situations.

1. On Employer's Premises

Did the injury or death occur on the employer's premises? If so, this factor favours coverage.

An employer's premises includes any land or buildings owned, leased, rented, or controlled (solely or shared) for the purpose of carrying out the employer's business. An employer's premises may also include:

- captive roads (see Item C3-19.00); and
- employer-provided facilities (see Item C3-20.00).

2. For Employer's Benefit

Did the injury or death occur while the worker was doing something for the benefit of the employer's business? If the worker is in the process of doing something for the benefit of the business generally or the employer personally, this factor favours coverage. If the worker is in the process of doing something solely for the worker's own benefit, this factor does not favour coverage.

In the case of independent operators and active principals of corporations, it is necessary to distinguish between the activities the independent operators or active principals carry on in furtherance of the business, and personal activities undertaken independent of the business. Only injuries or death occurring while pursuing the former type of activity may be considered to arise out of and in the course of a worker's employment.

3. Instructions From the Employer

Did the injury or death occur in the course of action taken in response to instructions from the employer? For example, did the employer direct or request that the worker participate in an activity as part of the employment? The clearer the direction, the more this factor favours coverage.

The more tenuous the direction, the less this factor favours coverage: for example, if the worker was doing something on a purely voluntary basis, or the employer simply sanctioned participation without directing or requesting it.

4. Equipment Supplied by the Employer

Did the injury or death occur while the worker was using equipment or materials supplied by the employer? If so, this factor favours coverage.

5. Receipt of Payment or Other Consideration from the Employer

Did the injury or death occur while the worker was in the process of receiving payment or other consideration from the employer? If so, this factor favours coverage.

This includes cases where the worker is required to report to the employer's premises or office in order to pick up a paycheque, whether or not this is during a regular shift.

6. During a Time Period for which the Worker was Being Paid or Receiving Other Consideration

Did the injury or death occur during a time period in which the worker was paid a salary or other consideration, or did the injury or death occur during paid working hours? If so, this is a factor that favours coverage.

7. Activity of the Employer, a Fellow Employee or the Worker

Was the injury or death caused by an activity of the employer or of a fellow employee? If so, this factor favours coverage.

Was the injury or death caused by a non-work related activity of the worker? The more tenuously the worker's activity is related to the employment, the less this factor favours coverage.

Consideration in either case is given to whether the activity of the employer, fellow employee or worker was employment-related or unauthorized (see Item C3-17.00).

8. Part of Job

Did the injury or death occur while the worker was performing activities that were part of the worker's job? If so, this factor favours coverage.

9. Supervision

Did the injury or death occur while the worker was being supervised by the employer or a representative of the employer having supervisory authority? If so, this factor favours coverage.

EFFECTIVE DATE:	February 1, 2020
AUTHORITY:	Section 134(1) of the *Act.*
CROSS REFERENCES:	Item C3-17.00, *Deviations from Employment*; Item C3-18.00, *Personal Acts*; Item C3-19.00, *Work-Related Travel*; Item C3-20.00, *Employer-Provided Facilities*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Policy amended to provide guidance on the legal issues of standard of proof, evidence, and causation. July 1, 2010 – This policy was amended to include content from former policy items #14.00, #21.30 and #21.40 of the *Rehabilitation Services & Claims Manual*, Volume II. June 1, 2004 − Former policy item #14.00 was amended to include "whether the injury occurred while the worker was performing activities that were part of the regular job duties" and "whether the injury occurred while the worker was being supervised by the employer" as factors to be considered. The amendment applied to all injuries on or after June 1, 2004 and was undertaken as part of the review of former policy item #20.20.
APPLICATION:	Applies to all decisions made on or after February 1, 2020, respecting claims for injuries occurring on or after July 1, 2010.

RE: Serious and Wilful Misconduct **ITEM: C3-14.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance for determining compensability for an injury or death due to the serious and wilful misconduct of a worker.

2. The Act

Section 134, in part:

(1) If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

(2) As an exception to subsection (1), if the injury is attributable solely to the serious and wilful misconduct of the worker, compensation is not payable unless the injury results in the worker's death or serious or permanent disablement.

...

POLICY

Before section 134(2) can be considered, it must first be determined under section 134(1) that the worker's personal injury or death arose out of and in the course of the worker's employment. Item C3-14.00 is the principal policy used for making this determination.

In weighing the evidence, the actions or conduct of the worker may induce the Board to conclude that the worker's injury or death did not arise out of and in the course of the worker's employment under section 134(1). If such a conclusion is reached, the claim is disallowed, and section 134(2) is not considered. This is so even in the event of death or serious or permanent disablement.

If it is determined that the worker's injury or death did arise out of and in the course of the worker's employment and there is an indication that misconduct of the worker played a role in the worker's injury or death, section 134(2) is then considered.

A. Serious and Wilful Misconduct by the Worker

The first question to be considered is, was the worker's misconduct serious and wilful?

A worker engages in serious and wilful misconduct if the worker deliberately and intentionally violates rules, regulations or laws known to the worker. Serious and wilful misconduct is a voluntary act by a worker with reckless disregard for the worker's own safety and which the worker should have recognized as having the potential to result in personal injury.

If a worker's misconduct was not serious and wilful, the injury that arose out of and in the course of the worker's employment is compensable.

B. Attributable Solely to the Worker's Serious and Wilful Misconduct

If a worker's misconduct was serious and wilful, the second question to be considered is, was the injury attributable solely to the worker's serious and wilful misconduct?

The word "solely" in this situation means that, without the worker's misconduct, the injury would not have resulted.

If a worker's injury is not attributable solely to the worker's serious and wilful misconduct, compensation is payable.

C. Death or Serious or Permanent Disablement

If a worker's injury is attributable solely to the worker's serious and wilful misconduct, the third question to be considered is, did the worker's injury result in death or serious or permanent disablement?

In this context, the word "serious" is used in a physical rather than an economic sense. For example, if a worker has suffered a sprained wrist or finger which causes only two or three weeks of lost wages, this may not be considered as a serious disablement even though the loss of earnings may cause a serious financial problem for the worker. If an injury results in a prolonged disability, however, it may be regarded as serious even though the initial injury appears minor.

If a worker's injury that was attributable solely to the worker's serious and wilful misconduct did not result in death or serious or permanent disablement, it is not compensable, even though it also arose out of and in the course of the worker's employment.

D. Employer's Experience Rating

Where the injury attributable solely to the serious and wilful misconduct of the worker resulted in death or serious or permanent disablement, the cost of all compensation paid on the claim is excluded from the employer's experience rating.

EFFECTIVE DATE:	June 1, 2022
AUTHORITY:	Section 134(2) of the *Act.*
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of a Worker's Employment*; Item C3-17.00, *Deviations from Employment*; Item C17-114.00, *Experience Rating Cost Exclusions*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	June 1, 2022 − Policy change to exclude from experience rating the cost of all compensation paid on claims where section 134(2) of the *Act* applies. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. July 1, 2010 − This policy replaced former policy item #16.60, *Serious and Wilful Misconduct*, of the *Rehabilitation Services & Claims Manual*, Volume II. The number of weeks of wage-loss benefits that must be paid before the costs of compensation will be excluded from an employer's experience rating changed from 13 weeks to 10 weeks in former policy item #16.60 effective September 28, 2002.
APPLICATION:	This Item applies to all decisions, including appellate decisions, made on or after June 1, 2022.

RE: Accident – Section 134(3) Presumption **ITEM: C3-14.20**

BACKGROUND

1. Explanatory Notes

This policy provides guidance for determining a worker's entitlement to compensation for personal injury caused by accident.

2. The Act

Section 1, in part:

> **"accident"**, in relation to a worker, includes
>
> (a) a wilful and intentional act that is not the act of the worker, and
>
> (b) a fortuitous event occasioned by a physical or natural cause;
>
> ...

Section 134(3):

> The following apply in relation to an injury caused by accident:
>
> (a) if the accident arose out of the worker's employment, unless the contrary is shown, it must be presumed that the injury occurred in the course of that employment;
>
> (b) if the accident occurred in the course of the worker's employment, unless the contrary is shown, it must be presumed that the injury arose out of that employment.

POLICY

The definition of "accident" provided in the *Act* is not an exclusive definition of the term; the word has been interpreted in its normal meaning of a traumatic incident. It has not, for example, been extended to cover injuries resulting from a routine work action or a series of such actions occurring over a period of time.

Section 134(3) of the *Act* creates the following presumption for injuries resulting from an accident:

- Where an injury is caused by an accident that arose out of the worker's employment, unless the contrary is shown, it is presumed that the injury occurred in the course of that employment.

- Where an injury is caused by an accident that occurred in the course of the worker's employment, unless the contrary is shown, it is presumed that the injury arose out of that employment.

Where an injury occurs at work as a result of any traumatic experience or external cause, it is usually from an accident to which the presumption in section 134(3) applies. For injuries resulting from an accident, evidence is only needed to establish either that the injury arose out of the worker's employment or that it arose in the course of the worker's employment. The other component of the test is presumed, unless there is evidence to the contrary.

The standard of proof to be applied in determining whether the presumption has been rebutted is proof on a balance of probabilities. Balance of probabilities means "more likely than not." The presumption is rebutted if opposing evidence shows that the contrary conclusion is the more likely. The presumption is not rebutted because there is a lack of evidence to support an employment connection. Every reasonable effort is made to obtain all available evidence.

Where there is no "accident", the presumption in section 134(3) does not apply.

The broad interpretation given to the term "accident" for the purpose of section 4(1) of the *Government Employees Compensation Act*, R.S.C. 1985, c. G-5 does not apply to section 134(3) of the *Workers Compensation Act*.

EFFECTIVE DATE:	February 1, 2020
AUTHORITY:	Section 134(3) of the *Act.*
CROSS REFERENCES:	Item C3-12.10*, Entitlement for Federal Government Employees*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	July 4, 2025 – Housekeeping changes. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Policy amended to provide guidance on legal issues of standard of proof, evidence, and causation. July 1, 2010 – This policy replaced former policy item #14.10 of the *Rehabilitation Services & Claims Manual*, Volume II.
APPLICATION:	Applies to all decisions made on or after February 1, 2020, respecting claims for injuries occurring on or after July 1, 2010.

RE: Hazards Arising from Nature **ITEM: C3-14.30**

BACKGROUND

1. Explanatory Notes

This policy provides guidance for determining a worker's entitlement to compensation for personal injury or death that is caused by a hazard arising from nature.

2. The Act

Section 1, in part:

> **"accident"**, in relation to a worker, includes
>
> (a) a wilful and intentional act that is not the act of the worker, and
>
> (b) a fortuitous event occasioned by a physical or natural cause;
>
> ...

Section 134:

> (1) If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.
>
> (2) As an exception to subsection (1), if the injury is attributable solely to the serious and wilful misconduct of the worker, compensation is not payable unless the injury results in the worker's death or serious or permanent disablement.
>
> (3) The following apply in relation to an injury caused by accident:
>
> (a) if the accident arose out of the worker's employment, unless the contrary is shown, it must be presumed that the injury occurred in the course of that employment;
>
> (b) if the accident occurred in the course of the employment, unless the contrary is shown, it must be presumed that the injury arose out of that employment.

POLICY

An injury or death may result from natural elements. For instance, a worker may be stung by an insect or plant or suffer from exposure to extreme weather conditions. An injury or death resulting from a natural element is considered to arise out of and in the course of a worker's employment where a particular activity required by the employment exposes the worker to these natural elements.

If an injury is caused by accident, the rebuttable presumption contained in section 134(3) of the *Act* applies.

The failure of a worker to wear protective clothing may in some cases be considered serious and wilful misconduct and grounds for denying a claim under section 134(2) of the *Act*.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Sections 134(1) to 134(3) of the *Act.*
CROSS REFERENCES:	Item C3-14.10, *Serious and Wilful Misconduct*; Item C3-14.20, *Accident – Section 134(3) Presumption*; Item C3-17.00, *Deviations from Employment*; Item C3-18.10, *Clothing and Footwear*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. July 1, 2010 − This policy resulted from the consolidation of former policy items #17.00, #17.10, #17.20 and #17.30 of the *Rehabilitation Services & Claims Manual*, Volume II.
APPLICATION:	This item applies to all claims for injuries occurring on or after July 1, 2010.

RE:	Injuries Following Natural Body Motions at Work	ITEM:	C3-15.00

BACKGROUND

1. Explanatory Notes

This policy sets out the principles to consider when determining the compensability of an injury following a natural body motion at work.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

Section 339(3):

> If the Board is making a decision respecting the compensation or rehabilitation of a worker and the evidence supporting different findings on an issue is evenly weighted in that case, the Board must resolve that issue in a manner that favours the worker.

POLICY

A natural body motion is one that is commonly performed as part of daily living. The motion may occur both at work and away from work. For instance, standing up from a chair or turning one's head to speak to someone, are considered natural body motions.

Item C3-14.00 is the principal policy for determining whether a worker's injury arises out of and in the course of the worker's employment. This policy provides additional guidance for determining the compensability of injuries that do not result from an accident, but which follow a natural body motion at work. In these circumstances, it is generally clear that the injury arose in the course of the worker's employment, and the adjudication rests on whether the injury also arose out of the worker's employment. The Board considers both whether:

- the natural body motion has an employment connection; and
- the natural body motion was of causative significance in producing the injury.

This policy applies whether the injury results from one motion or a series of motions occurring over a period of time.

A. Sufficient Employment Connection

A natural body motion is sufficiently connected to the worker's employment where the motion is required or incidental to the employment.

Sufficient employment connection may exist where, for example, a health care worker undertakes the employment activity of bending over to retrieve a lunch tray to serve to a patient. Sufficient employment connection may not exist where, for example, a worker undertakes the personal action of bending over to retrieve the worker's lunch from the office refrigerator.

If the natural body motion is not sufficiently connected to the employment, the personal injury did not arise out of the worker's employment and is therefore not compensable.

B. Causative Significance

A natural body motion is of causative significance in producing the injury where the evidence, and in particular the evidence relating to medical causation, shows that the motion was more than a trivial or insignificant aspect of the injury.

When reviewing medical evidence, the Board considers whether:

- the force and/or physical placement involved in performing the motion has the likelihood to be of causative significance in producing the injury;
- the symptoms are medically known to have a spontaneous occurrence, or are more likely to occur following a specific motion or series of motions;
- there is a temporal relationship between the motion and the onset of symptoms; and
- there is evidence of any non-work-related medical conditions that contributed to the injury.

The Board also considers any other relevant medical evidence to assist in determining whether a worker's injury arises out of and in the course of the worker's employment.

In addition to medical evidence, the Board considers the description of the activities or events leading up to the injury provided by the worker, any witnesses, and the employer.

Where the evidence does not support a finding that the motion had causative significance in producing the injury, it is not compensable. A speculative possibility that the motion contributed to the injury is not enough.

EFFECTIVE DATE:	February 1, 2020
AUTHORITY:	Section 134(1) of the *Act.*
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of a Worker's Employment*; Item C3-18.00, *Personal Acts*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Policy amended to provide guidance on the legal issues of standard of proof and evidence. July 1, 2010 – This policy replaced former policy item #15.20, *Injuries Following Motions at Work* of the *Rehabilitation Services & Claims Manual*, Volume II, and revised entitlement test requirements of "sufficient employment connection" and "causative significance" for injuries involving natural body motions at work.
APPLICATION:	Applies to all decisions made on or after February 1, 2020, respecting claims for injuries occurring on or after July 1, 2010.

RE: Pre-Existing Conditions or Diseases **ITEM: C3-16.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on distinguishing between injuries or death that arise out of and in the course of a worker's employment, and injuries or death that result from a worker's pre-existing conditions or diseases.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

POLICY

A. General

It is necessary to distinguish between injuries or death resulting from a worker's employment (which are compensable), and injuries or death resulting from a worker's pre-existing conditions or diseases (which are not compensable).

An injury or death is not compensable simply because it happened at work. It is also necessary to determine that it arose out of the worker's employment. This means that there must have been something in the worker's employment activity or situation that had causative significance in producing the injury or death.

A pre-existing condition or disease may be aggravated by an employment-related incident or trauma, or series of incidents or traumas. In such cases, the worker's resulting injury or death may be compensable.

In adjudicating these types of claims, the Board considers:

- the nature and extent of the pre-existing condition or disease;
- the nature and extent of the employment activity; and

- the relationship between the pre-existing condition or disease and the employment activity, including the degree to which the employment activity may have affected the pre-existing condition or disease.

Evidence that the pre-existing condition or disease has been accelerated, activated or advanced more quickly than would have occurred in the absence of the employment activity, may be confirmation that the aggravation resulted from the employment activity.

B. Pre-Existing Deteriorating Condition or Disease

If a worker's pre-existing condition or disease is a *deteriorating* condition or disease, the evidence is examined to determine whether or not, at the time of the injury or death, the pre-existing deteriorating condition or disease was at a critical point at which it was likely to result in a manifest disability.

If the injury or death is one that the worker would have sustained whether at work, at home, or elsewhere, regardless of the employment activity, then the employment was not of causative significance, and the injury or death is considered to have resulted from the pre-existing deteriorating condition or disease and is not compensable.

On the other hand, if the injury or death is one that the worker would not have sustained for months or years, but for the exceptional strain or circumstance of the employment activity, then the employment is of causative significance, and the injury or death may be compensable.

An example may help to illustrate the distinction. If the evidence shows that a worker has a pre-existing deteriorating heart condition, which could result in a heart attack at any time, an employment activity such as walking up one flight of stairs to their office would not mean that the employment activity was of causative significance in a resulting heart attack. On the other hand, if the worker was at the bottom-end of moving a 300-pound load up a flight of stairs, and the load slipped, causing the worker fright and strain, that strain or circumstance may mean that the employment activity was of causative significance and the resulting heart attack arose out of and in the course of the worker's employment.

In all cases, the medical and factual evidence is considered together, in order to determine the causative significance of the pre-existing deteriorating condition or disease, and the employment activity or situation, in the resulting injury or death.

C. Pre-Existing Non-Deteriorating Condition or Disease

If a worker's pre-existing condition or disease is not a deteriorating condition or disease, it may be said that an event at work "triggered" the pre-existing condition or disease resulting in an injury or death. This does not mean, however, that the resulting injury or disease is compensable. The circumstances, including the condition of the worker, are considered to determine whether the employment was of causative significance.

For example, a worker's injury resulting from falling to the floor during an epileptic seizure would likely occur regardless of the worker's employment activity. The employment activity would therefore be considered trivial or insignificant and the injury not compensable.

On the other hand, if the employment activity or situation results in injuries or death beyond those that might have flowed from the pre-existing condition or disease, the additional injuries or death resulting from the employment activity or situation may be compensable. For example, the causative significance of a worker's employment activity would be much more than trivial or insignificant where a worker's injury results from falling off a twelve foot scaffold during an epileptic seizure. Here, the employment situation results in injuries beyond those that might have flowed from the pre-existing condition, and though the epileptic seizure itself is not a compensable injury, the injuries resulting from falling off the scaffold may be compensable, due to the significance of the employment situation.

EFFECTIVE DATE:	February 1, 2020
AUTHORITY:	Section 134(1) of the *Act.*
CROSS REFERENCES:	Item C4-25.20, *Establishing Work Causation*; Item C17-114.00, *Experience Rating Cost Exclusions*; Item C17-114.40, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	June 1, 2024 − Housekeeping changes made to modernize terminology by removing gendered language. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Policy amended to provide guidance on the legal issues of standard of proof, evidence, and causation. July 1, 2010 – This policy replaced former policy items #15.00, #15.10 and #15.30 of the *Rehabilitation Services & Claims Manual*, Volume II.
APPLICATION:	Applies to all decisions made on or after February 1, 2020, respecting claims for injuries occurring on or after July 1, 2010.

RE: Pre-Existing Conditions – Specific Injuries **ITEM: C3-16.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the adjudication of claims for certain specific injuries that may originate from pre-existing conditions and be aggravated by something in the employment relationship.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

Section 125(1):

> The Board may, at any time, on its own initiative or on application, reopen a matter that had been previously decided under a compensation provision by the Board or an officer or employee of the Board if, since the decision was made in the matter,
>
> (a) there has been a recurrence of a worker's injury, or
>
> (b) there has been a significant change in a worker's medical condition that the Board had previously decided was compensable.

POLICY

Item C3-14.00 is the principal policy that provides guidance in deciding whether or not an injury or death arises out of and in the course of a worker's employment.

Item C3-16.00 distinguishes between injuries or death resulting from the worker's employment (which are compensable), and injuries or death resulting simply from a worker's pre-existing condition or disease (which are not compensable).

Though the following injuries may originate from a pre-existing condition, a worker's employment may have causative significance in aggravating or producing the injury such that it is considered to arise out of and in the course of the worker's employment.

A. Ganglia

Ganglia are generally not considered to be of traumatic origin and are normally not considered to arise out of and in the course of a worker's employment.

Exceptions may be made when:

1. a ganglion first appears between six weeks and six months following a deep penetrating wound or a contusion involving deep tissue damage at the site where the ganglion appears, or

2. a ganglion appears within six weeks of commencing work which is both unaccustomed and involves repetitive movements of joints or tendons at the site of the ganglion. The Board considers this to be an aggravation of the ganglion in a pre-disposed individual.

B. Herniae

i. General

There are two main types of herniae, inguinal (groin) herniae, and non-inguinal herniae (e.g., femoral, incisional, and umbilical herniae).

On the basis of the Board's present understanding of the biologic characteristics of herniae, the following principles are followed in the adjudication of hernia claims.

1. There must be increased intra-abdominal pressure, or evidence of severe direct trauma, resulting from the work or employment preceding the appearance of the hernia. Symptoms will generally appear shortly after the incident.

2. Given the preponderance of medical information indicating that herniae are multi-factorial in development, herniae will be considered an aggravation of a pre-existing condition, and surgery will be recognized as an attempt to correct the aggravation.

3. There is usually no urgency to the hernia operation, except where there are threatening complications, such as a bowel obstruction or inability to reduce the hernia. In most cases, there is no need to stop working while awaiting surgery.

Given the above, pre-operative wage-loss benefits will not normally be paid unless medical information is provided by the attending physician indicating the complication which restricts the worker's ability to continue working. Where an attending physician's report certifies that a worker is disabled pre-operatively, other objective evidence, such as a medical opinion, regarding the worker's condition may be sought to either verify or dispute the attending physician's opinion.

4. Where a worker suffers bilateral herniae, it is extremely unlikely that both will have resulted from the same incident. However, where a claim for one of those hernia is acceptable in accordance with the principles set out above, the Board will accept responsibility for both herniae if the evidence is such that it is not possible to determine which of the two herniae did result from the employment.

5. Usual recovery times for hernia surgical repair are based on medical protocols and procedures adopted by the Board.

ii. Prior Compensable and Non-Compensable Herniae

a. Prior Compensable Herniae

- Under 18 Months Since Surgery Date

If no new incident is reported, the Board may reopen the decision of a prior compensable hernia(e) where less than 18 months have passed since the surgery date for the prior compensable hernia and a ground for reopening is met. If a significant new trauma is reported, it is usually adjudicated as a new claim.

- Over 18 Months Since Surgery Date

A hernia claim that occurs 18 months or more after the surgery date for the worker's prior compensable hernia(e) is generally adjudicated as a new claim. This consideration, however, also includes evaluating the question of reopening the old claim. The claim can only be reopened where a ground for reopening is met.

b. Prior Non-Compensable Herniae

- Under 18 Months Since Surgery Date for Prior Herniae

There is a greater potential for recent hernia(e) repairs to break down in the first 18 months after a repair. For this reason a hernia claim that occurs less than 18 months after the worker's surgery date for a prior non-compensable hernia(e) is more likely to be a repair breakdown than a new injury. As a result, for the hernia

claim to be accepted, there must be clear evidence to establish a relationship of the breakdown to the worker's employment.

- Over 18 Months Since Surgery Date for Prior Herniae

A hernia claim that occurs more than 18 months after the worker's surgery date for a prior non-compensable hernia(e) is more likely to be a new injury than a breakdown of the prior non-compensable hernia(e) repair.

All claims are adjudicated on the merits and justice of the case.

C. Adverse Reactions to Inoculations or Injections

An injury or death that results from a worker's adverse reaction to an inoculation or injection may be considered to arise out of and in the course of the worker's employment if:

1. the inoculation or injection is required, either as a condition of the employment or as a condition of continued employment (such as where the worker has sustained an injury or contracted a disease outside the work environment, but the employer insists on precautionary measures being taken before the worker returns to employment),

2. due to concerns of a potential outbreak of some disease on the employer's premises, an employer advises that if the worker refuses to receive an inoculation or injection and there is an outbreak, the worker will not be permitted to work until after the outbreak has passed; for example, influenza immunizations for health care workers, or

3. the worker was convinced that it was necessary to receive an inoculation or injection in spite of objective evidence from the employer that the process was not compulsory.

An injury or death that results from a worker's adverse reaction to an inoculation or injection is not likely to be considered to arise out of and in the course of the worker's employment, if the inoculation or injection is received voluntarily by the worker, either as part of a broad program put on by the employer or in any other circumstances.

An injury or death that results from a worker's adverse reaction to a post-exposure prophylaxis ("PEP") that has been administered for a compensable exposure under Item C3-12.30 is adjudicated as a compensable consequence under Item C3-22.00.

EFFECTIVE DATE:	May 1, 2018
AUTHORITY:	Section 134(1) of the *Act.*
CROSS REFERENCES:	Item C3-12.30, *Infectious Agent or Disease Exposures*; Item C3-14.00, *Arising Out of and in the Course of a Worker's Employment*; Item C3-16.00, *Pre-Existing Conditions or Diseases*; Item C14-102.01, *Changing Previous Decisions – Reopenings*; Item C17-114.40, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. May 1, 2018 − This policy was revised to delete Section C., Prior Shoulder Dislocations. July 1, 2010 − This policy replaced former policy items #15.40, #15.50, #15.51, #15.60, and #19.41 of the *Rehabilitation Services & Claims Manual*, Volume II. December 1, 2004 − Housekeeping changes were made to correct grammar and to add practice references to former policy item #15.50. June 1, 2004 − Former policy item #15.50 was revised to delete an outdated timeframe for post-operative wage-loss benefits, extend general adjudicative principles to all types of hernia claims, and remove outdated content for various types of non-inguinal herniae, and applied to all decisions, including appellate decisions made on or after June 1, 2004. March 3, 2003 − Former policy item #15.51 was revised as to references to re-opening.
APPLICATION:	This item applies to all claims for injuries occurring on or after May 1, 2018.

RE: Deviations from Employment **ITEM: C3-17.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance for determining a worker's entitlement to compensation where a worker's participation in an unauthorized activity may have had causative significance in the worker's personal injury or death.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

POLICY

A. Introduction

Item C3-14.00 is the principal policy that provides guidance in deciding whether or not an injury or death arises out of and in the course of a worker's employment. In some circumstances, evidence supporting one component of the employment-connection test may be clear, while evidence supporting the other component is questionable, because the worker did something that was unauthorized by the employer, the employer condoned an unsafe practice, or some emergency forced the worker to act.

In considering whether an injury or death arose out of and in the course of a worker's employment, all relevant factors are taken into consideration including the causative significance of the worker's conduct in the occurrence of the injury or death and whether the worker's conduct was such a substantial deviation from the reasonable expectations of employment as to take the worker out of the course of the employment. An insubstantial deviation does not prevent an injury or death from being held to have arisen out of and in the course of a worker's employment.

Once it has been established that a worker's injury or death arose out of and in the course of the worker's employment, consideration may be given to whether the injury or

death is attributable solely to the serious and wilful misconduct of the worker under section 134(2) of the *Act*. (See Item C3-14.10.)

If a worker's injury or death is the result of a crime or an emergency action to prevent a crime, there may be entitlement to benefits under the *Crime Victim Assistance Act*, S.B.C. 2001, c.38, distinct from those available under the *Workers Compensation Act*.

The following provides guidance as to how some of the factors in Item C3-14.00 may be applied when considering the causative significance of a worker's unauthorized activity in the worker's personal injury or death.

B. Instructions of the Employer

It is clearly impossible for an employer to lay down fixed rules covering every detail of a worker's employment activity, so workers may be uncertain as to the limits of their work. Carelessness or exercising bad judgment are not bars to compensation where it is reasonable that a worker would exercise some discretion as part of the worker's employment. Thus an act that is done in good faith for the purpose of the employer's business may form part of a worker's employment, even if not specifically authorized by the employer.

On the other hand, a worker's injury or death may not be considered to arise out of and in the course of the worker's employment if the worker's act is specifically prohibited by an employer or is known or should reasonably have been known to the worker to be unauthorized, or if the worker has been previously warned against doing it. This is so even if the act could legitimately benefit the employer.

C. For Employer's Benefit

A worker's injury or death may be considered to arise out of and in the course of the worker's employment if the worker is acting to protect the employer's interests during an emergency. This may include protecting the employer's property or protecting an individual who is associated with the employment, such as a fellow worker or customer.

A worker's injury or death is not likely to be considered to arise out of and in the course of the worker's employment if the emergency action is that of a public spirited citizen, where the worker was doing no more than anyone would do, whether or not working for an employer at the time.

The distinction can perhaps best be illustrated by an example. A worker's injury or death may be considered to arise out of and in the course of the worker's employment where the worker receives a telephone call at work indicating that there is a fire in a portion of the employer's premises. The worker races from the office and, due only to haste, falls and injures an arm. There is no doubt that in light of the relationship of the emergency to the employment, this injury would be compensable.

On the other hand, a worker's injury or death is not likely to be considered to arise out of and in the course of the worker's employment where the worker receives a telephone call to the effect that a family member has been seriously injured in an accident. Once again the worker races from the office and, due only to haste, falls and injures an arm. The reason for the worker's departure is unrelated to the employment and nothing about the employment contributed to the injury.

The fact that the employment places a worker in a position to observe an emergency cannot be of itself a determinative factor in granting compensation.

D. Part of Job

If a generally unauthorized activity such as alcohol consumption is part of the permitted activities of the employment, a worker's employment may be considered to have causative significance in any injury or death that results from intoxication. For example, bartenders or sales representatives may be encouraged or permitted by their employers to drink with customers. The causative significance of the employment may be considered trivial or insignificant if the worker goes beyond the pursuit of the employer's interests to engage in a social event.

If a generally unauthorized activity such as alcohol consumption is not a permitted part of the employment, this does not automatically mean that an injury or death involving alcohol consumption did not also arise out of and in the course of a worker's employment. The Board considers the employment-connection test set out in Item C3-14.00 to determine whether the employment factors of the situation were of causative significance. Where the causative significance of the alcohol consumption is predominant in the resulting injury or death, and the employment factors are neutral or non-existent, this does not favour coverage.

E. On Employer's Premises

If an injury or death occurs in the course of the worker's employment and there are no other employment factors of causative significance to satisfy the "arising out of" component of the employment test, the injury or death will not be considered to arise out of and in the course of the worker's employment.

For example, if a worker stumbles while walking over normal ground as a result of intoxication or impairment, and is injured in the fall, nothing in the employment would have had any causative significance in producing the injury.

F. Activity of the Employer, a Fellow Employee or the Worker

i. Horseplay

If a generally unauthorized activity such as horseplay is a contributing factor of a worker's injury or death, the Board considers the degree of participation of the worker in the horseplay. For instance, a worker who instigates or provokes horseplay will more likely be considered to have made a substantial deviation from the course of the worker's employment than a worker who simply reacts to actions commenced or provoked by someone else.

The duration and seriousness of a worker's horseplay is also of relevance in considering whether there has been a substantial deviation from the course of the worker's employment. For example, if a worker walks over to a co-employee to engage in a friendly word, and accompanies this with a playful jab in the ribs, this is a trivial incident which would probably be considered an insubstantial deviation. On the other hand, playing a game of tag while driving the employer's forklifts would be considered a more substantial deviation.

ii Assault

If a worker's injury or death is the result of an assault that arises out of and in the course of the worker's employment, the worker may be entitled to compensation. However, if the worker's injury or death is the result of an assault that the worker initiated, this may constitute a substantial deviation from the course of the worker's employment.

The Board considers the spontaneity of the assault, whether the worker's aggressive response is in proportion to a triggering incident or provocation, whether there is a connection between the employment and the subject matter of the dispute that led to the assault. Where the actions or response of a worker are extreme or are out of proportion to a triggering incident or provocation, this may be an indication that the assault is of a more personal nature. If the subject matter of the dispute that led to the assault is a personal matter, the injury or death is not considered to have arisen out of and in the course of a worker's employment.

Just as a worker's initiation of an assault may take the worker out of the course of the employment, an assailant's attack on a worker may bring the worker into the course of the employment, even though the assault does not occur at the workplace or during working hours. An assailant may be an employer, fellow worker or a non-worker (for example, a client or customer).

In these cases, the facts of the situation as to whether the assault is clearly related to the worker's employment are carefully considered to determine whether the employment was of causative significance. If the employment aspects of the assault are more than just an incidental intrusion into the personal life of the worker at the moment of the injury or death, the worker may be entitled to compensation.

The term "assault", as used in this policy, includes sexual assault.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 134(1) of the *Act.*
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of a Worker's Employment*; Item C3-14.10, *Serious and Wilful Misconduct*; Item C3-18.00, *Personal Acts*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	June 1, 2024 − Housekeeping changes made to modernize terminology by removing gendered language. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. July 1, 2020 − This policy resulted from the consolidation of former policy items #16.00, #16.10, #16.20, #16.30, #16.40 and #16.50 of the *Rehabilitation Services & Claims Manual*, Volume II.
APPLICATION:	This Item applies to all claims for injuries occurring on or after July 1, 2010.

RE: Personal Acts **ITEM: C3-18.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance for differentiating between a worker's employment functions and a worker's personal actions, when determining whether a personal injury or death arises out of and in the course of the employment.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

Section 339(3):

> If the Board is making a decision respecting the compensation or rehabilitation of a worker and the evidence supporting different findings on an issue is evenly weighted in that case, the Board must resolve that issue in a manner that favours the worker.

POLICY

A worker's injury or death is compensable if it arises out of and in the course of the worker's employment, as described in Item C3-14.00. However, there is a broad intersection and overlap between employment and personal affairs. An incidental intrusion of personal activity into the process of employment is not a bar to compensation. Conversely, an incidental intrusion of some aspect of employment into the personal life of a worker at the moment of an injury or death does not automatically entitle the worker to compensation.

In the marginal cases, it is impossible to do better than weigh the employment features of the situation against the personal features to reach a conclusion, which can never be devoid of intuitive judgment, as to whether the test of employment connection has been met. For decisions respecting the compensation or rehabilitation of a worker, the standard of proof under section 339(3) of the *Act* is "at least as likely as not."

Where the common practice of an employer or an industry permits some latitude to workers to attend to matters of personal comfort or convenience in the course of employment, compensation for injuries or death occurring at those moments is not denied simply on the ground that the worker is not in the course of productive work activity at the crucial moment. This is within the scope of the established doctrine relating to acts which, though not in themselves productive, are nevertheless a normal incident of employment.

A. Lunch, Coffee and Other Breaks

A worker may be considered to be in the course of the worker's employment not only when doing the work the worker is employed to do, but also while engaged in other incidental activities. For example, a worker does not cease to be in the course of the worker's employment while using washroom facilities or having a lunch or coffee break on the employer's premises. An injury or death that occurs in these situations may not, however, also arise out of the worker's employment. While both employment and non-employment factors may contribute to the injury or death, the causative significance of the employment must be more than trivial for the Board to find that the injury or death arose out of the employment.

B. Acts for Personal Benefit of Principals of Business

An injury or death may be considered to arise out of and in the course of a worker's employment if it occurs while a worker is in the process of doing something for the benefit of the employer's business generally, or for the employer personally.

In the case of independent operators with Personal Coverage and active principals of small corporations, it is necessary to distinguish between the activities the independent operators or active principals carry on in furtherance of the business for which they (or the company) are covered by the *Act*, and independent, personal or business activities that are not so covered. Only injuries or death occurring while pursuing the former type of activity may be considered to arise out of and in the course of the employment.

EFFECTIVE DATE:	February 1, 2020
AUTHORITY:	Section 134(1) of the *Act.*
CROSS REFERENCES:	Item C3-20.00, *Employer-Provided Facilities* (Section C. Lunchrooms), of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	March 2, 2026 – Housekeeping change to update the term "Personal Optional Protection" to "Personal Coverage." April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Policy amended to provide guidance on the legal issue of standard of proof.

July 1, 2010 – This policy resulted from the consolidation of former policy items #21.00, #21.10, and #21.40 of the *Rehabilitation Services & Claims Manual*, Volume II.

APPLICATION: Applies to all decisions made on or after February 1, 2020, respecting claims for injuries occurring on or after July 1, 2010.

RE: Clothing and Footwear **ITEM: C3-18.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance for determining a worker's entitlement to compensation for personal injury or death sustained by a worker resulting from clothing or footwear.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

POLICY

Changing clothes prior to starting or after finishing work is generally a prerequisite to work and therefore not normally part of a worker's employment.

However, where changing clothes on the employer's premises is a requirement of the job, such as the donning and removal of protective garments, an injury or death resulting from this activity may be considered to arise out of and in the course of a worker's employment.

Injuries or death resulting from the wearing of clothing or footwear may be considered to arise out of and in the course of a worker's employment where the employment activity was of causative significance to the injury or death *and* the clothing or footwear was required by the employer for the job.

If there is nothing in the employment activity which would reasonably cause an injury or death and that injury or death can be seen to be directly related to the ill-fitting nature of the clothing or footwear, the injury or death does not arise out of and in the course of a worker's employment.

It is irrelevant who purchased the clothing or footwear.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 134(1) of the *Act.*
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of a Worker's Employment*; Item C3-18.00, *Personal Acts*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. July 1, 2010 − This policy replaces former policy item #20.41 of the *Rehabilitation Services & Claims Manual*, Volume II.
APPLICATION:	This Item applies to all claims for injuries occurring on or after July 1, 2010.

RE: Work-Related Travel **ITEM: C3-19.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance for determining a worker's entitlement to compensation for personal injury or death when engaged in work-related travel.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

POLICY

The general policy related to travel is that injuries or death occurring in the course of travel from the worker's home to the normal place of employment are not compensable. On the other hand, where a worker is employed to travel, injuries or death occurring in the course of travel may be covered. This is so whether the travel is a normal part of the job or is exceptional. In these cases, the worker is generally considered to be traveling in the course of the worker's employment from the time the worker commences travel on the public roadway.

In assessing work-related travel cases, the general factors listed under Item C3-14.00 are considered. Item C3-14.00 is the principal policy that provides guidance in deciding whether or not an injury or death arises out of and in the course of a worker's employment.

A. Regular Commute

An employment connection generally begins when the worker enters the employer's premises for the commencement of a shift, and terminates on the worker leaving the premises following the end of the shift.

Therefore, a worker's regular commute between home and the normal, regular or fixed place of employment is not generally considered to have an employment connection. This includes injuries or death that occur on a worker's regular or routine commute where:

- the employer provides the worker with a vehicle for the purpose of work and also allows the worker to use the vehicle for personal use outside of work hours; or
- the worker commutes to work in their own vehicle and uses the vehicle for a work purpose during the worker's shift.

There are, however, certain situations when a worker's regular commute may be considered part of a worker's employment.

The following provides guidance as to how some of the factors in Item C3-14.00 may be applied when considering specific cases relating to a worker's regular commute.

1. On Employer's Premises

Did the injury or death occur on the employer's premises? If so, this is a factor that favours coverage.

It is the responsibility of an employer to provide a safe means of access to and egress from the place of work. Thus, where a worker is traveling by public roadway to a place of work that is not adjacent to the public roadway, and must travel along a captive road or through a special hazard before reaching the employer's premises, the employment connection may begin at the point of departure from the public roadway rather than at the point of entry to the employer's premises.

It is not considered significant that an injury or death occurs while a worker is seeking to gain access to the employer's premises by a method that is different from that which the employer intends. However, it may be considered significant if the worker chooses a method that the worker has been advised is specifically forbidden by the employer, or if the worker chooses a route that is clearly dangerous.

a. Captive Road

Where a road is public, but as a practical matter is controlled by and leads only to the premises of the particular employer, the road can effectively be regarded as part of the employer's premises. The employer's control may be demonstrated by the fact that the employer makes decisions on maintenance or repairs of the public road. This is known as the "captive road" doctrine.

Where a road is privately owned by the employer, but in reality leads to the premises of several different employers and/or is used by the public, the road may not be considered part of the employer's premises. Consideration is given to other factors, such as the normal usage of the road and its relationship to the operation of the employer's business, not simply whether the employer legally owns or controls the road in question.

An injury or death is not compensable just because it happens on the employer's premises, nor is an injury or death compensable just because it occurs on a captive road. The circumstances surrounding the injury or death may indicate that, notwithstanding the place where it occurred, it did not arise out of and in the course of a worker's employment. All relevant factors are considered and no single factor is determinative.

An injury or death that occurs on a captive road is a factor that favours coverage, though it is not determinative. An injury or death on a captive road does not arise out of and in the course of a worker's employment if the journey along that road is not for a legitimate purpose associated with the employment.

b. Special Hazards of Access Route

Where a place of work is so located that for access and egress the worker must pass through special hazards beyond the ordinary risks of travel, an injury or death sustained from those hazards may be one arising out of and in the course of a worker's employment.

A "special hazard" for the purpose of this policy is one that goes beyond those hazards normally encountered by the traveling public and which the worker would not normally encounter, but for the location of the employer's premises.

For a claim to succeed on the grounds of a special hazard, the hazard need not lie on the only route to the employer's premises. It is sufficient if it is on the worker's regular commute route.

c. Extension of the Employer's Premises

An injury or death that occurs to a worker in the immediate approaches to the place of work, though still on the public roadway, may be considered to arise out of and in the course of a worker's employment if the hazard causing the injury or death is a spill-over from the employer's premises.

As well, if an employer provides a specific vehicle, like a crew bus, to transport its workers to and from the employer's premises, injuries or death occurring while traveling in this employer-controlled vehicle may be considered to arise out of and in the course of a worker's employment, as the crew bus is considered to be an extension of the employer's premises.

The employer's control of the transportation does not need to be exclusive for this factor to be in favour of coverage. For example, coverage may also be extended where the employer contracts out the crew bus service to transport its workers to and from work.

2. Instructions from the Employer

Was the worker instructed or otherwise directed by the employer? When considering specific cases relating to a worker's regular commute, this factor may favour coverage in the following circumstances.

a. Deviations From Route

An employment connection may be found where a worker is instructed by the employer to perform some activity related to work, which requires the worker to deviate from the worker's normal route while commuting. Generally speaking, an employment connection will only be found where, because of the employer's instructions, the worker is required to do something that would not normally be done while traveling to or from work, or to go somewhere where the worker would not normally go. A minor diversion from what is essentially a normal commute to or from work does not favour coverage.

Where an employer instructs or otherwise directs a worker to temporarily work at a place other than the normal, regular or fixed place of employment, an employment connection may be found for travel from the point at which the worker commences travel on the public roadway to the temporary work location. These workers are considered "traveling employees", which is discussed in Section C below. Once the temporary assignment becomes routine or consistent in nature, the travel will be considered a regular commute. This is assessed in the context of each individual case.

b. Emergency Response

An employment connection may also be found where, because of an emergency, a worker is directed or required by the employer to make a special trip to and from home and the employer's premises or to some other place where the job has to be done.

In cases of an emergency, if an injury or death results primarily from the activity associated with the urgency of the preparation for travel, it may be considered to arise out of and in the course of a worker's employment. This is an exception to the policy that workers who are employed to travel are generally considered to be in the course of the employment only from the time the worker commences travel on the public roadway.

B. Journeys to a Remote Worksite

There may be situations where a worker's journey is not simply a routine matter of driving to and from work on a regular commute, but there are also some additional circumstances which connect the journey with some particular aspect of the worker's

employment. This additional circumstance may be sufficient to bring all or part of the journey within the scope of the worker's employment.

The remoteness of a work site and the limited availability of transportation are factors which may suggest that a journey to or from the work site may be part of the employment. A journey between an established town and a remote place consisting only of a work site may be more hazardous and therefore more likely to favour coverage than a journey between two towns or cities with regular and established means of transportation.

If a person travels some distance on their own initiative looking for whatever jobs may be found, the person takes the risk of travel upon themselves.

C. Traveling Employees

"Traveling employees" are workers who:

- typically travel to more than one work location in the course of a normal work day as part of their employment duties; or

- have a normal, regular or fixed place of employment, and are directed by the employer to temporarily work at a place other than the normal, regular or fixed place of employment.

An employment connection generally exists throughout the travel undertaken by traveling employees, provided they travel reasonably directly and do not make major deviations for personal reasons. This is so regardless of whether public or private transportation is used.

An employment connection may not exist for the portion of travel between the traveling employee's home and the employer's premises that is undertaken at the commencement or termination of each work day. These workers may be considered to be on a "regular commute" for that portion of their travel, which is discussed in Section A above.

Examples of traveling employees include, but are not limited to, taxi drivers, emergency response personnel, transport-industry drivers, cable installers, home care workers, many sales representatives, and persons attending off-site business meetings.

One factor from Item C3-14.00 that may require further explanation in its application to specific cases relating to traveling employees is whether the travel is part of the job.

Travel to different work locations has an employment connection where a worker:

- terminates productive activity at one work location and travels to another work location to commence productive activity for the same employer. This is so

regardless of whether the worker was paid a salary or other consideration for the travel;

- travels from the employer's premises or assembly area, to another work location, after first reporting to the employer. This applies to a temporary worker who commutes to a labour supply firm each day, and then is dispatched to a client as, in these cases, the labour supply firm is the employer. This does not apply to a worker who goes to a union hiring hall and then is dispatched to an employer. The worker's travel from home to the employer's premises or assembly area would be considered a regular commute. The worker's travel from the employer's premises or assembly area to the point where the worker will begin work is normally considered to have an employment connection;

- routinely commences or terminates productive activity at varying work locations in the course of a normal work day. In these situations, the worker is generally considered to be in the course of the worker's employment from the time the worker commences travel on the public roadway. This could apply, for example, to cable installers and pharmaceutical sales representatives; or

- travels from home to a temporary place of work without first traveling to the normal, regular or fixed place of employment. Again, the employment connection begins when the worker commences travel on the public roadway.

An employment connection generally exists for traveling employees during normal meal or other incidental breaks, such as using the washroom facilities, so long as the worker does not make a distinct departure of a personal nature.

D. Business Trips

The general factors listed under Item C3-14.00 are used to determine whether a trip undertaken by a worker is sufficiently connected to the worker's employment as to be a business trip. For example, if the trip is taken for the employer's benefit, on the instructions of the employer, or paid for by the employer, these are all factors that weigh in favour of finding that the trip is a business trip.

An employment connection generally exists continuously during a business trip, except where the worker makes a distinct departure of a personal nature.

This means that injuries or death that result from a hazard of the environment into which a worker has been put by the business trip, including hazards of any overnight accommodation itself, are generally considered to arise out of and in the course of a worker's employment. However, injuries or death resulting from a hazard introduced to the premises by the worker for the worker's personal benefit may not be considered to

arise out of and in the course of the worker's employment, if no other factors demonstrate an employment connection.

Personal activities associated with and incidental to business trips, such as traveling, eating in restaurants, staying in overnight accommodations (including sleeping, washing etc.) are normally regarded as within the scope of a worker's employment where a worker is on a business trip.

On the other hand, when a worker makes a distinct departure of a personal nature while on a business trip, this may be regarded as outside the scope of the worker's employment. There is an obvious intersection and overlap between employment and personal affairs while a worker is on a business trip. However, a "distinct departure" is more than a brief and incidental diversion.

If a worker simply stops for a short refreshment break, this may be regarded as a brief and incidental diversion from the business trip and an employment connection may still be found. The employment connection may be broken where the injury or death occurs as a result of the worker's involvement in social or recreational activities that are not incidental to the business trip.

In the marginal cases, it is impossible to do better than weigh the business trip features of the situation against the personal features to reach a conclusion as to whether the injury or death arises out of and in the course of a worker's employment.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 134(1) of the *Act*.
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of a Worker's Employment*; Item C3-18.00, *Personal Acts*; Item C3-20.00, *Employer Provided Facilities*; Item C3-22.10, *Compensable Consequences – Travel*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	June 1, 2024 − Housekeeping changes made to modernize terminology by removing gendered language. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. July 1, 2010 − This policy resulted from the consolidation of former policy items #18.00, #18.01, #18.10, #18.11, #18.12, #18.20, #18.21, #18.22, #18.30, #18.31, #18.32, #18.33, #18.40, #18.41 and #18.42 of the *Rehabilitation Services & Claims Manual*, Volume II. February 24, 2004 − Former policy item #18.31 was revised and applied to all decisions made on or after February 24, 2004, to clarify that compensation is provided to workers from leaving home until their return home, if the workers are required to make a special journey to the employer's premises or some other place where the job was to be done,

because of an emergency or for some other reason, provided the workers do not deviate from their route.

APPLICATION: This Item applies to all claims for injuries occurring on or after July 1, 2010.

RE: Worker-Owned Tools and Equipment **ITEM: C3-19.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance for determining a worker's entitlement to compensation for personal injury or death sustained by a worker who provides their own tools or equipment for employment.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

POLICY

The fact that a worker is required to provide their own tools or equipment for a job does not mean that carrying or transporting the tools or equipment to work or away from work is part of the worker's employment. In most instances, injuries or death associated with carrying or transporting tools or equipment to or from work as part of a worker's regular commute do not arise out of and in the course of a worker's employment.

The carrying or transporting of tools or equipment may be sufficiently connected to the worker's employment where the worker's travel is not a regular commute and:

- the worker is a traveling employee; or
- the worker is on a business trip.

In such cases, an injury or death that results may be considered to arise out of and in the course of a worker's employment.

EFFECTIVE DATE: July 1, 2010
AUTHORITY: Section 134(1) of the *Act*.

CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of a Worker's Employment*; Item C3-19.00, *Work-Related Travel*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	June 1, 2024 − Housekeeping changes made to modernize terminology by removing gendered language. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. July 1, 2010 − This policy replaced former policy item #20.40 of the *Rehabilitation Services & Claims Manual*, Volume II.
APPLICATION:	This Item applies to all claims for injuries occurring on or after July 1, 2010.

RE: Employer-Provided Facilities **ITEM: C3-20.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance for determining a worker's entitlement to compensation for personal injury or death resulting from the use of employer-provided facilities.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

POLICY

Item C3-14.00 is the principal policy that provides guidance in deciding whether or not an injury or death arises out of and in the course of a worker's employment.

An injury or death that occurs when a worker uses an employer-provided facility may be considered to arise out of and in the course of a worker's employment.

An injury or death occurring in such circumstances generally is not considered to arise out of and in the course of a worker's employment if the injury or death results from exposure to a hazard or risk introduced by the worker into the workplace for the worker's own purposes, if no other factors demonstrate an employment connection.

It is not essential that the personal property that causes the injury or death be intrinsically hazardous. It is sufficient that it causes the injury or death in the particular case.

Facilities commonly supplied by employers include the following:

A. Accommodation

The use of employer-provided accommodation by a worker is generally connected to the worker's employment where the employer requires the worker to use that

accommodation, or there is no reasonable alternative accommodation. However, where an employer is simply providing accommodation for the worker as an additional service, and the availability of suitable alternative accommodation gives the worker a reasonable choice between that provided by the employer and that provided by others, the worker's use of the employer's accommodation is not connected to the employment.

Where a camp is isolated or for other reasons the worker has no reasonable choice about staying in accommodation provided by the employer, injuries or death resulting from the use of facilities on the camp site will normally be held to have arisen out of and in the course of a worker's employment. This applies not only to residential but also to recreational facilities.

Even where the employer-provided accommodation is not isolated and there is other available accommodation, an employment connection may exist where the employer-provided accommodation is provided free of charge and the worker would have to pay for other accommodation. In practice, most persons would stay in the employer-provided accommodation in such a situation and only those who had existing homes nearby would likely exercise the option to live elsewhere. The freedom of choice would be more theoretical than real and this may indicate that an employment connection extends to living in the employer-provided accommodation. While in the case of an isolated camp, injuries or death resulting from the use of both residential and recreational facilities will normally be held to have arisen out of and in the course of a worker's employment, the same will not necessarily be the case when the employer-provided accommodation is located close to a town and alternative recreational facilities. Economic factors may make a worker's freedom to choose the worker's own residence largely theoretical, but this does not extend to the choice of recreation.

B. Parking Lots

For the purpose of determining whether an injury or death occurring in a parking lot arises out of and in the course of a worker's employment, the Board considers Item C3-14.00 and the following additional questions. No single criterion is determinative.

1. Was the parking lot provided by the employer?

If the employer provides a parking lot for the use of a worker, this weighs in favour of coverage. However, the unauthorized use of a parking lot by a worker would normally weigh against the acceptance of a claim. There may, however, be exceptions where the employer, while not authorizing the parking, has condoned the practice by default in failing to take action to prohibit the practice.

2. Was the parking lot controlled by the employer?

If the parking lot is controlled by the employer, this weighs in favour of coverage. If control does not exist, there may be other factors that demonstrate an employment connection.

Control of a parking lot is not determined only by whether the parking lot is owned or leased by an employer. In assessing if an employer controls a parking lot used by a worker, the Board may also consider whether the employer was responsible for the operation, maintenance, or repair of the parking lot, or had the ability to control access to the parking lot.

In the absence of other factors demonstrating an employment connection, an injury or death that occurs on a shopping centre or shopping mall parking lot designed primarily for customer use and not controlled by the individual employer of a worker would not normally be considered to arise out of and in the course of a worker's employment.

3. Was the injury or death caused by a hazard of the parking lot?

If the injury or death was caused by a hazard of the parking lot, this weighs in favour of coverage.

The term "hazard of the parking lot" is intended to limit acceptance to only injuries or death which have an employment connection. This serves to distinguish between injuries or death resulting from personal causes and those resulting from the employment. In effect, the type of injury or death that would qualify for acceptance if it occurred on a factory floor would also qualify for acceptance if it occurred in a parking lot. For example, a slip on a pool of oil or a trip over an obstruction would weigh in favour of coverage. On the other hand, workers who close their own car doors on their fingers would not have their claims allowed. There will also be injuries or death which are not a direct result of the parking lot which may be considered to arise out of and in the course of a worker's employment, such as a worker struck by a fellow employee's car while walking on the parking lot.

4. Did the injury or death occur on a parking lot that was contiguous to the place of employment?

The word "contiguous" is defined as meaning both adjacent to and attached to.

If the injury or death occurs on a parking lot that is contiguous to the place of employment, this weighs in favour of coverage. If the injury or death occurs on a non-contiguous parking lot under the direction, supervision or control of an employer, this also weighs in favour of coverage. In the absence of other factors demonstrating an employment connection, injuries or death that occur while workers make their way across and along public thoroughfares between the place of employment and the non-

contiguous parking lot are not normally considered to arise out of and in the course of a worker's employment.

5. Did the injury or death occur proximal to the start or stop of a worker's shift?

In the absence of other factors demonstrating an employment connection, a significant time gap between the time of the worker's injury or death and the start or stop of the worker's shift, does not weigh in favour of coverage.

C. Lunchrooms

Injuries or death occurring in lunchrooms may be considered to arise out of and in the course of a worker's employment if the lunchroom is provided by the employer. This does not extend to injuries or death sustained through eating food, unless the food was provided by the employer, and the worker was specifically required to eat the food provided by the employer, or the food was provided as part of the worker's remuneration.

An employment connection generally exists for traveling employees during normal meal breaks. However, an employment connection generally does not exist where a non-traveling worker chooses to have a coffee break in a coffee shop away from the employer's premises, rather than use the company facilities.

D. Medical Facilities

An injury or death that results from the use of medical or first aid facilities may be considered to arise out of and in the course of a worker's employment, where such facilities are provided by the employer.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 134(1) of the *Act*.
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of a Worker's Employment*; Item C3-18.00, *Personal Acts* (Section A. Lunch, Coffee and Other Breaks); Item C3-19.00, *Work-Related Travel*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. July 1, 2010 − This policy resulted from the consolidation of former policy items #19.00, #19.10, #19.20, #19.30, #19.31 and #19.40 of the *Rehabilitation Services & Claims Manual*, Volume II.

APPLICATION: This Item applies to all claims for injuries occurring on or after July 1, 2010.

RE: Extra-Employment Activities **ITEM: C3-21.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance for determining a worker's entitlement to compensation for personal injury or death when engaged in extra-employment activities.

2. The Act

Section 1, in part:

> **"worker"** includes the following:
>
> …
>
> (b) a person who
>
> (i) is a learner who is not under a contract of service or apprenticeship; and
>
> (ii) becomes subject to the hazards of an industry within the scope of the compensation provisions for the purpose of undergoing training or probationary work specified by the employer as a preliminary to employment;
>
> ...

Section 6:

> (1) This section applies if the minister responsible for the *School Act* or the minister responsible for the *College and Institute Act*, as applicable, and the minister responsible for the administration of this Act approve
>
> (a) a vocational or training program, and
>
> (b) a school or other location as a place at which the vocational or training program is to be provided.
>
> (2) The Board may, at the request of a minister referred to in subsection (1), deem a person or class of persons enrolled in a

program approved under that subsection to be a worker or workers of the Crown in right of British Columbia.

(3) In relation to a person who is deemed to be a worker under subsection (2), compensation under this Act is payable under the compensation provisions for injuries to the worker arising out of and in the course of training for that worker.

(4) As limits on subsection (3), if an injury results in a period of temporary disability with no loss of earnings,

(a) subject to paragraph (b) of this subsection, a health care benefit only is payable, and

(b) if training allowances paid by Canada or British Columbia are suspended, the Board may, for the period the Board considers advisable, pay compensation in the amount of the training allowance.

(5) Admissions under this section may be made at the time, in the manner, subject to the terms and conditions and for the period the Board considers adequate and proper.

Section 134(1):

If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

Section 339(3):

If the Board is making a decision respecting the compensation or rehabilitation of a worker and the evidence supporting different findings on an issue is evenly weighted in that case, the Board must resolve that issue in a manner that favours the worker.

POLICY

Activities which people undertake outside the course of their employment are for their own benefit, and injuries or death occurring in the course of these activities are generally not compensable. However, some extra-employment activities may be sufficiently connected to the worker's employment as to be considered part of that employment.

In assessing these cases, the general factors listed under Item C3-14.00 are considered. Item C3-14.00 is the principal policy that provides guidance in deciding whether or not an injury or death arises out of and in the course of a worker's employment. All relevant factors must be considered and no single factor is determinative. Relevant factors not listed in policy may also be considered. The evidence is then weighed to determine whether the injury or death arose out of and in the course of the worker's employment. For decisions respecting the compensation or rehabilitation of a worker, the standard of proof applied under section 339(3) the *Act* is "at least as likely as not."

A. Participation in Competitions

Subject to the general factors listed under Item C3-14.00, an injury or death sustained by a worker while participating in, or while traveling to or from, an employment-related competition (such as a first aid, mine rescue, or fire-fighting competition), is considered to arise out of and in the course of the worker's employment if all three of the following conditions are satisfied.

1. The type of skill or knowledge that the competition is designed to test or promote is connected to the worker's employment. It is not necessary that the worker function in the tested capacity regularly or on a full-time basis. It is sufficient if the worker functions in the capacity on a standby basis while having another regular job function (for example, a worker who also serves the role of first aid attendant at their workplace).

2. The worker is a participant in the competition, not merely a spectator. The worker is considered a participant if any of the following apply:

   (a) the worker is a participating or reserve member of a competing team;

   (b) the worker is a coach or trainer;

   (c) the worker is appointed or assigned to assist in the organization or administration of the event; or

   (d) the worker has job responsibilities relating to the skills being tested in the competition, or is training for such responsibilities, and is attending to improve the worker's skill or knowledge relating to those responsibilities.

3. The worker's participation in the competition is sponsored or requested in some way by the employer. If the employer has not specifically requested the worker to attend, this may be implied from the circumstances. For example, a request for the worker to attend may be implied if any of the following apply:

   (a) the worker is paid for the whole or any part of the period of participation;

   (b) the worker is paid for the whole or any part of the time spent in training for the event;

   (c) the employer makes some contribution towards the expenses of the worker for attending the event; or

   (d) the employer provides supplies or equipment for the worker's participation or training for the event.

An injury sustained by a worker while practising or training for a competition may arise out of and in the course of the worker's employment, as discussed in Section B below.

B. Recreational, Exercise or Sports Activities

The organization of, or participation in, recreational, exercise or sports activities or physical exercises is not normally considered to be part of a worker's employment under the *Act*. There are, however, exceptional cases when such activities may be considered to have an employment connection. The obvious one is where the main job for which a worker is hired is to organize and participate in recreational activities. There may also be cases where, although the organization or participation in such activities is not the main function of the job, the circumstances are such that a particular activity can be said to be part of a worker's employment.

i. Application of Item C3-14.00 Factors

The following provides guidance as to how some of the factors in Item C3-14.00 may be applied when considering specific cases relating to recreational, exercise or sports activities.

1. Part of Job

Was the activity part of the job? If so, this is a factor that favours coverage. For example, a ski instructor injured while engaging in personal skiing activities unrelated to the instruction of pupils would not be covered. However, coverage may be provided if the skiing activity involved the instructor's pupils and was deemed part of the teaching activities.

2. Instructions from the Employer

Was the worker instructed or otherwise directed by the employer to carry out the exercise activity or to participate in the sports, exercise or recreational activity? For example, did the employer direct, request or demand that the worker participate in an activity as part of the worker's employment? The clearer the direction, the more likely this will favour coverage.

Was participation purely voluntary on the part of the worker? In some instances the employer may simply sanction participation without directing or requesting participation. If so, this is a factor that does not favour coverage.

3. During Working Hours

Did the recreational, exercise or sports activity occur during normal working hours? If so, this is a factor that favours coverage.

Where recreational, exercise or sports activities occur outside of normal working hours, including paid lunch breaks, this does not favour coverage. However, this factor does not automatically preclude coverage. For example, coverage may be extended where a teacher is injured while coaching or supervising a student soccer game in the schoolyard during their lunch break or after school.

Coverage under the *Act* cannot be extended by an employer simply by labeling an off-duty recreational, exercise or sport activity as mandatory.

4. Receipt of Payment or Other Consideration from the Employer

Was the worker paid a salary or other consideration while participating in the activity? The payment of salary favours coverage. If salary or other consideration was not paid, this does not favour coverage.

5. Supervision

Was the activity supervised by a representative of the employer having supervisory authority? If so, this favours coverage. If the activity was not supervised, this does not favour coverage.

6. On Employer's Premises

Did the activity take place on the employer's premises? If so, this is a factor favouring coverage.

Coverage is normally not extended to recreational, exercise or sports activities occurring off the employer's premises. However, coverage is not automatically precluded. Rather, a weighing of all relevant factors is required. For example,

coverage may be extended where a teacher is injured while supervising students during an off-site sports day during regular school hours organized by the employer.

ii. Factors Unique to Recreational, Exercise or Sports Activities

In addition to the factors in Item C3-14.00, the following factors may also be considered in determining whether a recreational, exercise or sports-related injury or death arises out of and in the course of a worker's employment.

1. Fitness a Job Requirement

Was physical fitness a requirement of the job? This factor is concerned with whether fitness is required in order to perform the job (e.g. muscle strength or aerobic capacity). If physical fitness is a requirement of the job, this is a factor favouring coverage.

Fitness training or exercise is more likely to be viewed as a job requirement where a significant degree of aerobic capacity or strength is needed to perform the job properly, but the work itself does not provide sufficient conditioning. This may be the case, for instance, for certain professionals such as police or firefighters, who may require the ability to react quickly to sudden and strenuous emergencies.

It is recognized that any recreation or exercise activity which adds to a worker's general health and enjoyment of life may be said to assist them in their work and, therefore, to benefit their employer. However, to cover these activities under the *Act* for that reason alone would obviously be to expand its horizons far beyond what the *Act* intended.

2. Public Relations for Benefit of Employer

Was there an intention to foster good relations with the public, or a section of the public with which the worker deals? A worker may have been injured while engaged in a recreational, exercise or sport activity, on behalf of the employer, involving the public, or a section of the public, which was clearly designed to foster good community relations. If so, this is a factor favouring coverage.

C. Educational or Training Courses

Compensation coverage does not generally extend to injuries or death that occur during educational or training courses. Such courses are generally for the worker's own benefit, and are not considered to have sufficient employment connection as to be compensable.

i. Education Sufficiently Connected to the Employment

However, some types of educational or training courses may be sufficiently connected to the worker's employment as to be considered part of that employment. Consideration is then given to the factors in Item C3-14.00 and any other relevant

factors not listed in policy, and the evidence is weighed to determine whether the injury or death arose out of and in the course of the worker's employment.

Factors that may weigh in favour of coverage for injuries or death sustained during educational or training courses include whether the education or training:

- took place on the employer's premises;
- was for the benefit of the employer's business;
- was undertaken at the direction of the employer;
- involved using equipment supplied by the employer;
- was during a time period for which the worker was being paid;
- was paid for by the employer; or
- was considered by the employer to be part of the worker's job.

No single factor is determinative. In marginal cases, it is impossible to do better than weigh the employment features of the education or training against the personal features to reach a conclusion as to whether the test of employment connection has been met.

ii. Education as Employment

In addition, there are three specific situations where the educational or training course is considered to be the worker's employment, and the question to be determined is whether the injury or death arose out of and in the course of the worker's education or training itself:

- Board-recognized vocational or training programs under section 6 of the *Act*.

- Vocational rehabilitation programs undertaken as part of a Board-approved rehabilitation plan (see Items C11-88.50 and C3-22.00).

- Pre-employment training or probationary work, undertaken by a person who is not under a contract of service or apprenticeship, that was specified by an employer as a preliminary to employment and which subjects the person to the hazards of an industry within the scope of the compensation provisions of the *Act*.

D. Fundraising, Charitable or Other Similar Activities

The organization of, or participation in, fundraising or charitable activities is normally not considered to be part of a worker's employment under the *Act*. There are, however, certain cases when such activities may be considered sufficiently connected to the worker's employment as to be considered part of the worker's employment.

The factors listed in Item C3-14.00 are considered in determining whether coverage should be provided for an injury or death sustained during a fundraising or charitable activity. All relevant factors must be considered and no single factor is determinative. Relevant factors not listed in policy may also be considered.

The above guidance does not apply to persons who are employees of charitable or other like agencies which are covered under the *Act*, or to persons from other companies who are seconded for a period of time to work with such agencies and who are considered workers of those agencies under the *Act*.

EFFECTIVE DATE:	February 1, 2020
AUTHORITY:	Section 134(1) of the *Act*.
CROSS REFERENCES:	Item C2-4.10, *Coverage for Volunteer Firefighters*; Item C3-12.20, *Commencement and Termination of the Employment Relationship*; Item C3-14.00, *Arising Out of and In the Course of a Worker's Employment*; Item C11-88.50, *Vocational Rehabilitation – Formal Training*; Item C17-114.00, *Experience Rating Cost Exclusions*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	June 1, 2024 − Housekeeping changes made to modernize terminology by removing gendered language. October 21, 2020 − Housekeeping amendments to the *Act* portion of the Background section to reflect amendments to the *Act* by the *Workers Compensation Amendment Act*, *2020* (Bill 23 of 2020), in effect August 14, 2020. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Policy amended to provide guidance on the legal issue of standard of proof. July 1, 2010 – This policy resulted from the consolidation of former policy items #20.00, #20.10, #20.20, #20.30 and #20.50 of the *Rehabilitation Services & Claims Manual*, Volume II. June 1, 2004 – Former policy item #20.20 was amended to clarify each of the factors listed in policy and to indicate which factors favour coverage. As part of the review of former policy item #20.20, former policy item #20.50 was also amended to clarify that fundraising or charitable activities are not normally considered to be part of a worker's employment, though in certain circumstances such activities may be covered; cross-reference former policy item #14.00; and delete discussion of the test in then section 5(1) of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492. Changes to both former policies applied to all injuries on or after June 1, 2004.
APPLICATION:	Applies to all decisions made on or after February 1, 2020, respecting claims for injuries occurring on or after July 1, 2010.

RE: Compensable Consequences **ITEM: C3-22.00**

BACKGROUND

1. Explanatory Notes

This policy provides general guidance for determining a worker's entitlement to compensation for a further injury, increased disablement, disease, or death that is a consequence of a compensable injury.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

Section 157, in part:

> (1) Health care provided … must at all times be subject to the direction, supervision and control of the Board …
>
> (2) All questions as to the necessity, character and sufficiency of health care to be provided are to be determined by the Board.
>
> ...

Section 160:

> (1) The Board must permit health care to be administered, so far as the selection of a physician or qualified practitioner is concerned, by a physician or qualified practitioner who may be selected or employed by the injured worker.
>
> (2) Subsection (1) does not limit the powers of the Board under this Division respecting the supervision and provision of health care in every case where the Board considers the exercise of those powers is expedient.

Section 229, in part:

(1) In this section:

"former Act" means the *Workers Compensation Act*, R.S.B.C. 1996, c. 492;

"transition date" means June 30, 2002, being the date on which this section came into force.

(2) This section applies to an injury that occurred before the transition date.

(3) Subject to subsections (4) to (8), the former Act, as it read immediately before the transition date [June 30, 2002], applies to an injury that occurred before the transition date [June 30, 2002].

(4) Subject to subsections (5) to (8), if a worker's permanent disability first occurs on or after the transition date [June 30, 2002] as a result of an injury that occurred before the transition date [June 30, 2002], this Act applies to the permanent disability.

…

(8) If a worker has, on or after the transition date [June 30, 2002], a recurrence of a disability that results from an injury that occurred before the transition date [June 30, 2002], the Board must determine compensation for the recurrence based on this Act.

Section 125(1):

The Board may at any time, on its own initiative or on application, reopen a matter that had been previously decided under a compensation provision by the Board or an officer or employee of the Board if, since the decision was made in the matter,

(a) there has been a recurrence of a worker's injury, or

(b) there has been a significant change in a worker's medical condition that the Board has previously decided was compensable.

POLICY

If a worker's original compensable injury was before June 30, 2002, the compensable consequences of that injury are adjudicated under the policies in Volume I of the

Rehabilitation Services & Claims Manual. The only exception to this rule occurs when the claim falls under the transitional provisions of section 229(4) or (8) of the *Act*. In these situations, the further permanent disability or recurrence of disability is adjudicated under the policies contained in Volume II. Please refer to policy item #1.03 of Volume I or Item C1-1.00 of Volume II for further guidance with respect to these claims.

A. Compensable Consequences of Employment-Related Injuries

Once it is established that an injury arose out of and in the course of a worker's employment, the question arises as to what consequences of that injury are compensable. While the worker may be entitled to health care benefits for as long as the worker continues to experience the effects of the compensable injury itself, not all consequences of employment-related injuries are also compensable.

Looking at the matter broadly and from a "common sense" point of view, the Board considers whether the compensable injury, or the worker's condition resulting from the compensable injury, was of causative significance in the further injury, increased disablement, disease, or death. If the compensable injury, or the worker's condition resulting from the compensable injury, was of causative significance in the further injury, increased disablement, disease, or death, then the further injury, increased disablement, disease, or death is sufficiently connected to the compensable injury so that it forms an inseparable part of the compensable injury and is therefore also compensable.

This is distinct from a recurrence of the worker's compensable injury.
(See Item C14-102.01.)

If a compensable injury accelerates a worker's need for treatment for a pre-existing non-compensable condition, the Board accepts responsibility for both the treatment and the consequences of that treatment. This is so even if such treatment would likely have been required at some point in the future in any event. In these circumstances, consideration is then given to relief of costs under section 240(1)(d).

B. Aggravation Due to Subsequent Non-Compensable Incidents

A subsequent non-compensable incident may include:

- sustaining a non-compensable injury, condition, disease, or disability; or
- undergoing surgery, tests or other treatment for a non-compensable injury, condition, disease, or disability.

In the event that a worker temporarily suspends treatment for a compensable injury because of personal reasons, such as a family emergency or a vacation, this would not be considered a subsequent non-compensable incident.

If a worker's condition resulting from the compensable injury is aggravated by a subsequent non-compensable incident, the Board does not consider the subsequent non-compensable incident to form part of the compensable injury, or that the increased level of disability is compensable. This is true regardless of the fact that the subsequent non-compensable incident would not have been as significant if the condition that resulted from the compensable injury had not existed.

The only exception to this is if the condition resulting from the compensable injury actually causes the fall or other non-compensable incident that brings about the aggravation.

C. Compensable Consequences of Treatment

Where a further injury, increased disablement, disease, or death arises as a direct consequence of treatment for a compensable injury, it is sufficiently connected to the original employment-related injury as to form part of that injury. The further injury, increased disablement, disease, or death is therefore considered to arise out of and in the course of a worker's employment and is also compensable.

Where a worker is undergoing treatment for a compensable injury, the place of treatment is analogous to a place of employment. A further injury, increased disablement, disease, or death arising at the place of treatment is compensable provided it is consistent with the worker being at the place of treatment for the purpose of treatment and does not result from activities of a personal nature. The further injury, increased disablement, disease, or death in these cases is compensable because it is sufficiently connected to the original employment-related injury so that it forms part of that injury and is therefore considered to arise out of and in the course of the worker's employment. For example, if a worker is undergoing treatment at a hospital for a compensable injury and sustains a further injury by stumbling down the stairs in the hospital while en route to a treatment appointment, the further injury is also compensable.

While the Board does pay compensation for injuries, increased disablement, disease, or death arising as a direct consequence of treatment for a compensable injury, this does not extend to further injuries, increased disablement, diseases, or death that result from ordinary exercises performed at home long after the worker has recovered, the condition has stabilized, or the worker is in receipt of permanent disability benefits. Such exercises are usually for the purpose of preventing further problems rather than for treating an existing condition.

D. Compensable Consequences of Surgery

Ordinarily, when a worker undertakes surgery for a compensable injury, the consequences of the surgery are considered to be sufficiently connected to the original compensable injury as to form part of that injury. Any further injury, increased

disablement, disease, or death resulting from the surgery is treated as compensable on the basis that it arose out of and in the course of a worker's employment.

In cases where the Board has declined to authorize surgery and the worker undertakes it anyway, the worker might be viewed as having introduced an intervening cause of injury, increased disablement, disease, or death so that the further injury, increased disablement, disease, or death is not sufficiently connected to the original compensable injury as to form part of that injury. To determine whether the worker has introduced an intervening cause, the Board considers the pre-operative opinion of the treating physician or surgeon that the worker would benefit from the surgery, the operative report, and any other relevant medical information. However, the connection between the original compensable injury and the further injury, increased disablement, disease, or death is not severed simply because the surgery was not authorized by the Board.

The above rules only apply where the surgery resulted from the compensable injury. The Board accepts no responsibility for the cost of surgery or any resulting injury, increased disablement, disease, or death where the surgery was not a consequence of the compensable injury.

E. Compensable Consequences of Board-Related Assessments

Where a worker is attending at the Board or the Workers' Compensation Appeal Tribunal by prearranged appointment for the purpose of an enquiry, medical examination, interview, discussion, review or appeal in respect of a claim which has been accepted, or which is subsequently accepted, and where the worker suffers a further injury, increased disablement, disease, or death arising out of and in the course of such an appointment, the further injury, increased disablement, disease, or death may be compensable.

Where a worker sustains a further injury, increased disablement, disease, or death while participating in a vocational rehabilitation program undertaken as part of a Board-approved rehabilitation plan, the further injury, increased disablement, disease, or death may be regarded as a compensable consequence of the compensable injury.

EFFECTIVE DATE:	October 21, 2020
AUTHORITY:	Section 134(1) of the *Act*.
CROSS REFERENCES:	Item C1-1.00, *Scope of Manual*; Item C3-14.00, *Arising Out of and In the Course of a Worker's Employment*; Item C3-22.10, *Compensable Consequences – Travel*; Item C3-22.20, *Compensable Consequences – Pain and Chronic Pain*; Item C3-22.30, *Compensable Consequences – Psychological Impairment*;

Item C3-22.40, *Compensable Consequences – Certain Diseases and Conditions*;
Item C10-72.00, *Health Care – Introduction;*
Item C10-73.00, *Direction, Supervision, and Control of Health Care*;
Item C11-88.50, *Vocational Rehabilitation – Formal Training*;
Item C14-102.01, *Changing Previous Decisions – Reopenings*;
Item C17-114.00, *Experience Rating Cost Exclusions*;
Item C17-114.70, *Certain Compensable Consequences*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:

December 1, 2025 − Housekeeping change to update internal cross-reference, consequential to reformatting and renumbering Chapter 1, *Scope of Volume II of this Manual*.
October 21, 2020 − Amended to reflect amendments to health care provisions of the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
This policy resulted from the consolidation of former policy items #22.00, #22.10, #22.11, #22.12, #22.13, #22.20 and #22.21 of the *Rehabilitation Services & Claims Manual*, Volume II.
February 1, 2004 − Former policy items #22.00, #22.10, #22.11, and #22.21 were amended to clarify respectively that, if the work injury was a significant cause of a further injury, then the further injury forms part of the work injury; a further injury arising out of the place of treatment is compensable provided it is consistent with the worker being at the place of treatment for the purpose of treatment and does not result from activities of a personal nature; when a worker undertakes surgery for a work injury, the consequences of the surgery are considered to be sufficiently connected to the original work injury as to form part of that injury; and a further injury is compensable because it is sufficiently connected to the original work injury as to form part of that injury. Any further injuries or disablement are compensable on the basis that they arose out of and in the course of the employment. These amendments applied to all decisions, including appellate decisions, made on or after February 1, 2004 regardless of the date of the original work injury or the further injury.

APPLICATION:

Applies to all decisions made on or after October 21, 2020, respecting claims for injuries occurring on or after July 1, 2010.

RE:	Compensable Consequences – Travel	ITEM:	C3-22.10

BACKGROUND

1. Explanatory Notes

This policy provides guidance for determining a worker's entitlement to compensation for a further injury, increased disablement or death that occurs during travel undertaken as a consequence of a compensable injury.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided by this Part must be paid by the Board out of the accident fund.

POLICY

A. Generally Non-Compensable Travel

The places of treatment, appointment or rehabilitation that a worker attends because of a compensable injury are considered analogous to the worker's place of employment. Travel to and from places of treatment, appointment or rehabilitation, are therefore considered analogous to the worker's regular commute to and from work. For this reason, further injuries, increased disablement or death sustained in the course of this travel are not generally compensable. This includes such travel as:

- going to the office of the attending physician for advice, examination or treatment;
- attending for diagnostic imaging services or laboratory tests when associated with a visit to the office of the attending physician and not involving a special journey from home;
- traveling to undergo a course of treatments, whether at the office of a medical specialist, the out-patient department of a hospital, a physiotherapist's office, or any other type of health care provider;

- travel to a drugstore for the purchase of drugs or other medical supplies; or
- travel to an optician or optometrist, prosthetist, orthotist, or hearing aid service provider in connection with medical supplies or the fulfillment of prescriptions.

Any injuries, increased disablement or death sustained in the course of travel for any other types of visits or attendances which are part of a routine (analogous to traveling to and from work) or which are analogous to personal shopping are also not compensable.

B. Generally Compensable Travel

On the other hand, further injuries, increased disablement or death sustained in the course of a special or exceptional journey may be compensable because the special or exceptional journey is sufficiently connected to the compensable injury and is not analogous to a regular commute.

1. Emergency Transportation

Where a compensable injury has just occurred and a worker is being transported to a hospital or other place of emergency treatment, and a further injury, increased disablement or death occurs in the course of such transportation, the further injury, increased disablement or death may also be compensable. This is so whether the worker is traveling on foot, by ambulance, by automobile, by aircraft, or by any kind of vehicle; and it is so regardless of the ownership of the vehicle, and regardless of whether the worker is driving the vehicle or being carried as a passenger.

2. Treatment-Related Vehicles

If a worker is traveling to or from a place of treatment for a compensable injury and sustains a further injury, increased disablement or death while traveling in a vehicle that is provided by an institution engaged in the provision of treatment, or in the provision of a vehicle for the conveyance of patients for treatment, the further injury, increased disablement or death may be compensable.

3. Exceptional Travel

If a worker is traveling by prearranged appointment to a place of exceptional medical treatment, or for an exceptional examination, an injury, increased disablement or death that occurs in the course of travel to or from that place of treatment may be compensable. This includes such travel as:

- traveling to a hospital for admittance as an inpatient, or traveling home following discharge from a hospital as an inpatient;
- traveling to any other place of special treatment that involves living away from home for the duration of the treatment;

- traveling in relation to a referral by the attending physician to a specialist for a special examination or treatment (but not for a course of treatments);

- traveling for diagnostic imaging services or laboratory tests where this involves a special journey separate from any attendance for routine treatment;

- traveling to a social or rehabilitation agency in connection with assistance in the diagnosis, handling, treatment or care of medical or rehabilitation problems related to the compensable injury on referral by the attending physician, or by the Board;

- traveling on referral by a physician or qualified practitioner to another physician or qualified practitioner for a second opinion;

- traveling for a medical examination at the Board by prearranged appointment with the Board, or for a medical examination elsewhere approved by the Board in connection with a compensable injury;

- traveling to or from the Board for a prearranged appointment for the purpose of an enquiry, interview, discussion, or review in respect of a claim that has been accepted, or that is subsequently accepted; or

- traveling to or from a prearranged appointment at the Workers' Compensation Appeal Tribunal in respect of a claim that has been accepted, or that is subsequently accepted.

EFFECTIVE DATE: July 1, 2010
AUTHORITY: Section 134(1) of the *Act*.
CROSS REFERENCES: Item C3-14.00, *Arising Out of and In the Course of a Worker's Employment*;
Item C3-19.00, *Work-Related Travel*;
Item C3-22.00, *Compensable Consequences*;
Item C17-114.70, *Certain Compensable Consequences*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY: April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
July 1, 2010 − This policy replaced former policy item #22.15 of the *Rehabilitation Services & Claims Manual*, Volume II.
February 1, 2004 − Former policy item #22.15 was amended to clarify that travel to the place of treatment is generally comparable to a regular commute to work, but, where a worker is injured in the course of a special or exceptional journey for medical treatment, the further injury is compensable. Any further injuries or disablement are compensable on

the basis that they arose out of and in the course of the employment. This amendment applied to all decisions, including appellate decisions, made on or after February 1, 2004 regardless of the date of the original work injury or the further injury.

APPLICATION: This Item applies to all claims for injuries occurring on or after July 1, 2010.

RE: Compensable Consequences – Pain and Chronic Pain **ITEM: C3-22.20**

BACKGROUND

1. Explanatory Notes

This policy provides guidance for determining a worker's entitlement to compensation for pain or chronic pain as a compensable consequence of a worker's personal injury.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

POLICY

A worker's pain symptoms may be accepted as compensable where the evidence indicates that the pain results as a consequence of an employment-related injury or occupational disease. This policy discusses the scope of coverage in cases where pain is accepted as compensable. Pain is not assessed as a psychological impairment.

A. Definitions

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. It includes cognitive, affective, behavioural and physiological components.

The Board recognizes three main stages of pain:

- Acute pain is pain that coincides with a traumatic injury or disease and the early stages of recovery. In the vast majority of cases acute pain eventually resolves, either spontaneously or with some form of treatment.

- Subacute pain is pain that an injured worker continues to experience four to six weeks after a traumatic injury or disease.

- Chronic pain is pain that persists six months after an injury or occupational disease and beyond the usual recovery time for that injury or disease. Chronic pain is further distinguished as either specific or non-specific as set out in Item C6-39.10.

Usual recovery times for injuries or diseases are based on medical protocols and procedures adopted by the Board. These medical protocols set out the points in time, after an injury, when a worker should regain pre-accident functional ability, or reach maximum medical recovery.

In determining the appropriate recovery time for an injury, the Board may, in consultation with a Board Medical Advisor, consider the medical protocols as well as other factors such as the worker's pre-injury health status and any treatments received that would likely impact the recovery time of the compensable injury.

B. Early Intervention – Acute and Subacute Pain

Early intervention involves the provision of early return to work assistance and/or focused multidisciplinary treatment and rehabilitation, to expedite the worker's medical recovery and return to work. Early intervention at the acute or subacute stages of pain is essential as both rehabilitation and prevention measures in deterring the development of chronic pain. Studies indicate that even with some residual or recurrent pain symptoms, workers do not have to wait until they are completely pain free to return to work. Early intervention should be incorporated into the worker's rehabilitation plan.

i. Early Return to Work Assistance

In the majority of cases following an injury, a worker is able to return to work shortly after an injury without Board assistance. The provision of early return to work assistance for a worker experiencing acute or subacute pain that is affecting the worker's return to work efforts will be considered as soon as the worker is medically able to participate. The Board will coordinate the worker's early return to work plan in collaboration with the worker, the attending physician, a Board Medical Advisor, the employer and treating clinicians as needed.

In developing an early return to work plan, the Board may consider the worker's entitlement to vocational rehabilitation programs and services such as graduated return to work assistance, placement assistance and work site/job modifications where the Board concludes that they will assist in a worker's return to work.

ii. Multidisciplinary Treatment and Rehabilitation

In certain cases, the Board may consider it appropriate to refer the worker for focused multidisciplinary treatment and/or rehabilitation intervention. These interventions are

preferred in cases where the Board concludes that they will assist in the worker's early return to work. The Board may also consider these interventions where they will assist in preventing the onset of chronic pain.

In making this determination, the Board may consult with a Board Medical Advisor and/or a Board Psychologist. The worker's attending physician may also be consulted to confirm their agreement with the proposed intervention.

A multidisciplinary approach may include one or more of the following: medical management, physical conditioning, work conditioning, pain and stress management, ergonomic consultation, and vocational counseling and placement.

In determining what specific treatment or rehabilitation intervention is appropriate for a worker, the Board may refer the worker for a multidisciplinary assessment. A multidisciplinary assessment is an evaluation of the worker by a physician, a psychologist, a physiotherapist, an occupational therapist, or other provider as the Board determines appropriate.

A multidisciplinary assessment may involve consideration of the worker's medical history, health status, physical limitations, psychological state, behaviour, and workplace issues. The evaluation will provide an opinion on the treatment or rehabilitation intervention, or combination of interventions that would be appropriate to aid in the worker's recovery and return to work.

iii. Early Intervention – Chronic Pain

In all cases where the Board considers that a worker may be experiencing chronic pain symptoms, a multidisciplinary assessment must be undertaken. This evaluation will provide an opinion on whether a worker is experiencing chronic pain as a consequence of a compensable injury. The evaluation will also provide an opinion on the appropriate course of treatment and rehabilitation for the worker.

C. Compensation

Where a worker is participating in treatment and/or rehabilitation for temporarily disabling pain, a worker's entitlement to temporary wage-loss benefits may be considered under section 191 or 192 of the *Act*.

Where chronic pain is considered by the Board to become permanent, entitlement to permanent partial disability benefits is considered under sections 195 and 196 of the *Act*.

EFFECTIVE DATE:	January 1, 2021
AUTHORITY:	Section 134(1) of the *Act*.
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of a Worker's Employment*; Item C3-22.00, *Compensable Consequences*; Item C3-22.30, *Compensable Consequences – Psychological Impairment*; Chapter 5 – Wage-Loss Benefits; Chapter 6 – Permanent Disability Benefits; Item C6-39.10, *Chronic Pain*; Chapter 11 – Vocational Rehabilitation; Item C11-88.00, *Vocational Rehabilitation − Nature and Extent of Programs and Services*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	June 1, 2024 – Housekeeping changes made to modernize terminology by removing gendered language. January 1, 2021 – Policy changes made consequential to implementing the permanent partial disability benefits provisions of the *Workers Compensation Amendment Act, 2020* (Bill 23). April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Policy amended to provide guidance on the legal issues of standard of proof, evidence, and causation. July 1, 2010 – This policy replaced former policy item #22.35 of the *Rehabilitation Services & Claims Manual*, Volume II. January 1, 2003 − Former policy item #22.35 was created to set out the scope of coverage in cases where pain is accepted as compensable; applied to all new claims received and all active claims awaiting an initial adjudication of chronic pain on a claim.
APPLICATION:	Applies to all decisions, including appellate decisions, made on or after January 1, 2021, respecting claims for injuries occurring on or after July 1, 2010.

RE: Compensable Consequences – Psychological Impairment **ITEM: C3-22.30**

BACKGROUND

1. Explanatory Notes

This policy provides guidance for determining a worker's entitlement to compensation for psychological impairment as a compensable consequence of a worker's personal injury.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

POLICY

Psychological impairment may be accepted as compensable where the evidence indicates that it results as a consequence of an employment-related injury or occupational disease.

It cannot be assumed that a psychological impairment exists simply because the worker has unexplained subjective complaints or is having difficulty in psychologically or emotionally adjusting to any physical limitations resulting from a compensable injury or disease. There must be evidence that the worker has a psychological impairment.

The worker may be entitled to health care benefits for as long as the worker has a psychological impairment that is a compensable consequence of an injury accepted under section 134(1) or occupational disease accepted under section 136(1). When the psychological impairment is temporarily disabling, the worker is also entitled to wage-loss benefits under section 191 or 192 of the *Act*.

When the psychological impairment becomes permanent, it will be necessary to determine whether there is entitlement to permanent disability benefits. The decision-making procedure for assessing entitlement to permanent disability benefits for psychological impairment is found in Item C6-39.00.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 134(1) of the *Act*.
CROSS REFERENCES:	Item C3-12.00, *Personal Injury*; Item C3-14.00, *Arising Out of and In the Course of a Worker's Employment*; Item C3-22.00, *Compensable Consequences*; Item C3-22.20, *Compensable Consequences – Pain and Chronic Pain*; Chapter 5 – Wage-Loss Benefits and Return to Work Obligations; Item C6-39.00, *Section 195 Permanent Partial Disability Benefits*; Item C10-72.00, *Health Care – Introduction*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	February 1, 2022 – Housekeeping amendments to update references to former policy item #39.01. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. July 1, 2010 − This policy replaced former policy item #22.33 of the *Rehabilitation Services & Claims Manual*, Volume II.
APPLICATION:	This Item applies to all claims for injuries occurring on or after July 1, 2010.

RE: Compensable Consequences – Certain Diseases and Conditions **ITEM: C3-22.40**

BACKGROUND

1. Explanatory Notes

This policy provides guidance for determining a worker's entitlement to compensation for certain specific diseases or conditions that may be considered a compensable consequence of a worker's personal injury.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

POLICY

Once it is established that an injury arose out of and in the course of a worker's employment, a disease or condition beyond the immediate physical damage caused by the compensable injury may also be considered to be a consequence of the compensable injury. If the compensable injury was of causative significance in the subsequent disease or condition, then the subsequent disease or condition is sufficiently connected to the worker's compensable injury as to be considered to arise out of and in the course of the worker's employment, and is therefore also compensable.

A. Suicide

In a case of suicide, death benefits are payable if it is established that the suicide resulted from a compensable injury.

If the employment-related compensable injury was of causative significance in the suicide, then the suicide is sufficiently connected to the employment-related injury as to also be compensable. Consideration is given to the worker's mental health history and any evidence of causal connections between the employment-related injury and the suicide.

B. Alcoholism and Drug Dependency Problems

Where it is claimed that an alcohol or drug dependency problem was caused or made worse by a compensable injury, the compensability of the alcohol or drug dependency problem is thoroughly investigated in the same manner as followed in investigating the relationship of other problems to an injury. Because of the psychological nature of alcohol and drug dependency problems, this investigation would normally include a reference to a Board Psychologist, though the decision on acceptability will be made by the Board officer adjudicating the claim. Any pre-existing alcohol or drug dependency problems are treated in the same way as any other pre-existing condition. The Board determines whether the worker's alcohol or drug dependency problem is a continuation of a pre-existing alcohol or drug dependency problem, or has resulted from or been made worse by the compensable injury.

If the Board accepts one alcohol or drug dependency problem as a compensable consequence of an injury, it does not mean the Board will accept all such problems. Any further or subsequent alcohol or drug dependency problem is investigated, following the procedure set out above. The Board determines whether the further alcohol or drug dependency problem is related to the compensable injury and the previously accepted alcohol or drug dependency problem, or to some pre-existing condition or other cause.

Policy regarding the prescription of narcotics and other drugs of addiction is set out in Item C10-80.00.

Compensation for alcoholism as an occupational disease is addressed in Section C. of Item C4-32.00.

EFFECTIVE DATE:	June 1, 2024
AUTHORITY:	Section 134(1) of the *Act*.
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of a Worker's Employment*; Item C3-16.00, *Pre-Existing Conditions or Diseases*; Item C3-22.00, *Compensable Consequences*; Item C3-22.30, *Compensable Consequences – Psychological Impairment*; Item C4-32.00, *Other Matters* (Section C.i. Alcoholism); Item C10-80.00, *Potentially Addictive Drugs*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	June 1, 2024 − This policy was revised to delete section B. Cancer. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Policy amended to provide guidance on the legal issues of standard of proof, evidence, and causation.

January 1, 2015 – Consequential amendments were made arising from changes to Chapter 10, *Health Care, Rehabilitation Services & Claims Manual*.
January 1, 2014 – This policy was revised to delete section B, Multiple Sclerosis.
July 1, 2010 – This policy resulted from the consolidation of former policy items #22.22, #22.30, #22.31, #22.32, and #22.34 of the *Rehabilitation Services & Claims Manual*, Volume II.
The criteria to be met before considering whether a cancer is traumatically induced set out in former policy item #22.32 was derived from J. Ewing's "Modern Attitude Toward Traumatic Cancer", *Archives of Pathology* 19:690-728, 1935. The statement that there is no causal relationship between bone cancer and trauma is based on the following four studies:
Coley, W.B.; *Neoplasms of Bone,* Paul Haber Inc., 2nd ed., 1960;
Dahlin, David C.; *Bone Tumours,* Charles C. Thomas, 3rd ed., 1978;
Monkman et al.; *Trauma and Oncogenesis,* Mayo Clinic Proceedings 49:157-163, March 1974; and
Pritchard et al.; *The Etiology of Osteosarcoma,* Clinical Orthopedics and Related Research, 111:14-22, September 1975

APPLICATION: Applies to all decisions made on or after June 1, 2024, respecting claims for injuries occurring on or after January 1, 2014.

RE:	Replacement and Repair of Personal Possessions – Section 161(1)	ITEM:	C3-23.00

BACKGROUND

1. Explanatory Notes

This policy provides an introduction to the compensation available for the replacement and repair of artificial appliances, eyeglasses, dentures and hearing aids.

This policy also explains the compensation available for other personal possessions of a worker that are damaged or broken at work and the application of section 161(1) to federal government employees.

2. The Act

Section 1, in part:

> **"accident"**, in relation to a worker, includes
>
> (a) a wilful and intentional act that is not the act of the worker, and
>
> (b) a fortuitous event occasioned by a physical or natural cause;
>
> ...

Section 161(1):

> The Board may assume the responsibility of replacement and repair of the following for a worker:
>
> (a) artificial appliances, including artificial members damaged or broken as the result of an accident arising out of and in the course of the worker's employment;
>
> (b) eyeglasses, dentures and hearing aids broken as a result of an accident arising out of and in the course of the worker's employment if
>
> (i) that breakage is accompanied by objective signs of personal injury to the worker, or
>
> (ii) where there is no personal injury, the accident is otherwise corroborated and the Board is satisfied the worker was not at fault.

POLICY

A. Authority under Section 161(1)

Compensation may be paid where artificial appliances are damaged or broken as a result of an accident arising out of and in the course of the worker's employment.

Compensation may also be paid where eyeglasses, dentures or hearing aids are broken as a result of an accident arising out of and in the course of the worker's employment.

B. Personal Possessions

Except for the circumstances set out in section 161(1) of the *Act* regarding artificial appliances, eyeglasses, dentures and hearing aids damaged or broken as the result of an accident arising out of and in the course of the worker's employment, the Board cannot accept responsibility for damage to a worker's personal possessions.

C. Replacement and Repair Costs

When a claim satisfies the requirements of section 161(1), the worker is reimbursed the amount charged by the supplier or repairer of the appliance in question. The amount payable is not limited to what the Board would pay for a similar appliance required for a worker as the result of an injury covered by section 134(1) of the *Act*.

D. Federal Government Employees

Section 4 of the *Government Employees Compensation Act*, R.S.C. 1985, c. G-5 provides that employees of the federal government are only eligible for compensation where there has been a work-related accident causing personal injury (or disability resulting from an occupationally-acquired disease). For this reason, health care coverage by the Board is limited to those situations where the worker also sustains a personal injury. Therefore, the Board does not assume responsibility for the replacement or repair of a federal employee's damaged artificial appliances or broken artificial appliances, eyeglasses, dentures and hearing aids, unless the accident that caused the damage or breakage also caused the worker personal injury.

EFFECTIVE DATE: July 1, 2010
AUTHORITY: Section 161(1) of the *Act*.
CROSS REFERENCES: Item C3-23.10, *Section 161(1)(a) – Artificial Appliances*;
Item C3-23.20, *Section 161(1)(b) – Eyeglasses, Dentures and Hearing Aids*;

Item C3-23.30, *Section 161(1) – Wage-Loss Benefits During the Replacement or Repair Period*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY: April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
July 1, 2010 − This policy replaced former policy item #23.00 and incorporates concepts from former policy items #23.10, #23.40 and #23.70 of the *Rehabilitation Services & Claims Manual,* Volume II.

APPLICATION: This Item applies to all claims for injuries occurring on or after July 1, 2010.

RE: Section 161(1)(a) – Artificial Appliances **ITEM: C3-23.10**

BACKGROUND

1. Explanatory Notes

This policy sets out the criteria that must be met for a worker to be entitled to compensation for the replacement or repair of artificial appliances.

2. The Act

Section 1, in part:

> **"accident"**, in relation to a worker, includes
>
> (a) a wilful and intentional act that is not the act of the worker, and
>
> (b) a fortuitous event occasioned by a physical or natural cause;
>
> ...

Section 161(1):

> The Board may assume the responsibility of replacement and repair of the following for a worker:
>
> (a) artificial appliances, including artificial members damaged or broken as the result of an accident arising out of and in the course of the worker's employment;

POLICY

A. Definitions

"Artificial appliances" include:

- prosthetic devices, e.g., prosthetic eyes, prosthetic noses, implants, mastectomy bras, prosthetic limbs, etc.
- orthotic devices, e.g., spinal orthoses, knee braces, modified footwear, etc.

- assistive technology devices specifically related to mobility, e.g., crutches, canes, walkers, scooters, manual wheelchairs, power wheelchairs, etc.

This is not an exhaustive list.

B. Factors for Coverage

The Board may assume the responsibility for replacement and repair of artificial appliances if both of the following conditions are met:

i. The artificial appliance is damaged or broken.

The Board also assumes responsibility if the artificial appliance is lost or inaccessible as the result of an accident, if it is reasonable to assume that it is in fact broken.

There is no legislated requirement that the breakage or damage of the artificial appliance be accompanied by objective signs of personal injury, or corroboration of the accident and proof that the worker was not at fault, as is necessary for broken eyeglasses, dentures and hearing aids.

ii. The damage or breakage of the artificial appliance is the result of an accident arising out of and in the course of the worker's employment.

A chance event involving damage or breakage to the artificial appliance without any personal injury to the worker is only considered an "accident" for the purposes of section 161(1) if it had the potential or reasonable probability of causing harm or personal injury to the worker.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 161(1) of the *Act*.
CROSS REFERENCES:	Item C3-14.20, *Accident – Section 134(3) Presumption*; Item C3-23.00, *Replacement and Repair of Personal Possessions – Section 161(1)*; Item C3-23.20, *Section 161(1)(b) – Eyeglasses, Dentures and Hearing Aids*; Item C3-23.30, *Section 161(1) – Wage Loss Benefits During the Replacement or Repair Period*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

APPLICATION:	July 1, 2010 − Incorporates concepts from former policy items #23.30 and #23.40 of the *Rehabilitation Services & Claims Manual*, Volume II. This Item applies to all claims for injuries occurring on or after July 1, 2010.

RE:	Section 161(1)(b) – Eyeglasses, Dentures and Hearing Aids	ITEM:	C3-23.20

BACKGROUND

1. Explanatory Notes

This policy sets out the criteria that must be met for a worker to be entitled to compensation for the replacement or repair of eyeglasses, dentures and hearing aids.

2. The Act

Section 1, in part:

> **"accident"**, in relation to a worker, includes
>
> (a) a wilful and intentional act that is not the act of the worker, and
>
> (b) a fortuitous event occasioned by a physical or natural cause;
>
> ...

Section 161(1), in part:

> The Board may assume the responsibility of replacement and repair of the following for a worker:
>
> …
>
> (b) eyeglasses, dentures and hearing aids broken as a result of an accident arising out of and in the course of the worker's employment if
>
> (i) that breakage is accompanied by objective signs of personal injury to the worker, or
>
> (ii) where there is no personal injury, the accident is otherwise corroborated and the Board is satisfied the worker was not at fault.

POLICY

A. Definitions

"Eyeglasses" include contact lenses.

"Dentures" do not include dental crowns or fixed bridgework, which are regarded as part of the anatomy, and adjudicated under section 134(1).

B. Factors For Coverage

In determining whether to assume responsibility for the replacement and repair of eyeglasses, dentures and hearing aids, the following questions are considered:

i. Were the eyeglasses, dentures or hearing aids broken?

The Board also assumes responsibility if the eyeglasses, dentures and hearing aids are lost or inaccessible as the result of an accident, if it is reasonable to assume that they are in fact broken.

ii. Was the breakage a result of an accident arising out of and in the course of the worker's employment?

A chance event involving breakage to the eyeglasses, dentures or hearing aids without any personal injury to the worker is only considered an "accident" for the purposes of section 161(1) if it had the potential or reasonable probability of causing harm or personal injury to the worker.

iii. Did the worker suffer a personal injury?

If there are objective signs of personal injury, the Board may assume the responsibility for replacement and repair of the broken eyeglasses, dentures and hearing aids.

If there are no objective signs of personal injury, the following further questions are also considered:

(a) Can the accident be otherwise corroborated?

It is not sufficient for the worker to simply provide evidence that the breakage or damage has occurred, nor is it sufficient for the worker to simply report that an accident has occurred. Rather, there must be some corroboration of the worker's evidence that will support the worker's statement of the facts.

Normally corroboration consists of the evidence of witnesses to the accident. However, where there are no such witnesses, other evidence that suggests that an accident had occurred will be considered. This may include a worker's spontaneous exclamation of the accident, the evidence of others who had overheard the exclamation, or other circumstantial evidence which suggests that an accident had occurred.

(b) Is the Board satisfied the worker was not at fault?

Any negligent or careless act or omission of the worker is weighed against the causative significance of the worker's employment in contributing to the breakage of the eyeglasses, dentures or hearing aids.

Minor lapses of attention are reasonable to expect from the average worker in the normal course of work and will not generally outweigh the employment aspects of the situation.

After weighing all the relevant factors, if the worker's negligence is considered more than a trivial or insignificant cause of the breakage, the worker is considered to be at fault, and the Board will not assume the responsibility of replacement or repair of the broken eyeglasses, dentures or hearing aids. Alternatively, if there is no negligence, or the worker's negligence is considered trivial or insignificant, the worker is not considered to be at fault, and the Board will assume responsibility for the necessary replacement or repair of the broken item.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 161(1) of the *Act*.
CROSS REFERENCES:	Item C3-12.00, *Personal Injury*; Item C3-14.20, *Accident – Section 134(3) Presumption*; Item C3-23.00, *Replacement and Repair of Personal Possessions – Section 161(1)*; Item C12-97.00, *Evidence – General*; Item C12-97.10, *Evidence Evenly Weighted*; Item C12-97.20, *Presumptions*; Item C12-97.30, *Medical Evidence*; Item C12-97.40, *Evidence – Other Matters*; Item C12-97.50, *Surveillance*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. July 1, 2010 − Incorporates concepts from former policy items #23.20, #23.30, #23.40, #23.50, and #23.60 of the *Rehabilitation Services & Claims Manual*, Volume II.
APPLICATION:	This Item applies to all claims for injuries occurring on or after July 1, 2010.

RE: Section 161(1) – Wage-Loss Benefits During the Replacement or Repair Period **ITEM: C3-23.30**

BACKGROUND

1. Explanatory Notes

This policy provides guidance with respect to wage-loss benefits for a worker awaiting the repair or replacement of an artificial appliance, eyeglasses, dentures and hearing aids.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

Section 161(1):

> The Board may assume the responsibility of replacement and repair of the following for a worker:
>
> (a) artificial appliances, including artificial members damaged or broken as the result of an accident arising out of and in the course of the employment;
>
> (b) eyeglasses, dentures and hearing aids broken as a result of an accident arising out of and in the course of the worker's employment if
>
> (i) that breakage is accompanied by objective signs of personal injury to the worker, or
>
> (ii) where there is no personal injury, the accident is otherwise corroborated and the Board is satisfied the worker was not at fault.

Section 191(1), in part:

> … if a temporary total disability results from a worker's injury, the Board must pay the worker compensation…

Section 192(1), in part:

> … if a temporary partial disability results from a worker's injury, the Board must pay the worker compensation…

POLICY

Wage-loss benefits are payable only where a compensable injury causes a period of temporary disability from work. Broken or damaged artificial appliances, eyeglasses, dentures or hearing aids are not personal injuries.

Section 161(1) does not provide authority for the Board to pay a worker wage-loss benefits when there is a delay in replacing the broken or damaged artificial appliance, eyeglasses, dentures or hearing aids and the only reason the worker is unable to work is because the worker is without the broken or damaged item. Similarly, it does not provide authority for the Board to pay wage-loss where the worker has to take time off from work in order to be fitted for the item or to pick it up when ready.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 161(1) of the *Act*.
CROSS REFERENCES:	Item C3-23.00, *Replacement and Repair of Personal Possessions – Section 161(1)*; Item C3-23.10, *Section 161(1)(a) – Artificial Appliances*; Item C3-23.20, *Section 161(1)(b) – Eyeglasses, Dentures and Hearing Aids*; Item C5-33.00, *Introduction to Compensation For Temporary Disability*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. July 1, 2010 − This policy replaced former policy item #23.70 of the *Rehabilitation Services & Claims Manual*, Volume II.
APPLICATION:	This Item applies to all claims for injuries occurring on or after July 1, 2010.

RE: Section 135 – Mental Disorders	ITEM: C3-24.00

BACKGROUND

1. Explanatory Notes

This is the principal policy that sets out the decision-making principles for determining a worker's entitlement to compensation under section 135 of the *Act*.

2. The Act

Section 135, in part:

(1) Subject to subsection (3), a worker is entitled to compensation for a mental disorder, payable as if the mental disorder were a personal injury arising out of and in the course of a worker's employment, if that mental disorder does not result from an injury for which the worker is otherwise entitled to compensation under this Part, and only if all of the following apply:

(a) the mental disorder is either

(i) a reaction to one or more traumatic events arising out of and in the course of the worker's employment, or

(ii) predominantly caused by a significant work-related stressor, including bullying or harassment, or a cumulative series of significant work-related stressors, arising out of and in the course of the worker's employment;

(b) the mental disorder is diagnosed by a psychiatrist or psychologist as a mental or physical condition that is described, at the time of diagnosis, in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association;

(c) the mental disorder is not caused by a decision of the worker's employer relating to the worker's employment, including a decision to change the work to be performed or the working conditions, to discipline the worker or to terminate the worker's employment.

…

(3) The Board may require that a psychiatrist or psychologist appointed by the Board review a diagnosis made for the purposes of subsection (1)(b) and may consider that review in determining whether a worker is entitled to compensation for a mental disorder.

(4) Section 163 *[duties of physicians and qualified practitioners]* applies to a psychiatrist or psychologist who makes a diagnosis referred to in this section.

(5) In this section:

…

"psychiatrist" means a physician who is authorized to practise in the speciality of psychiatry by

(a) the regulator that is responsible, under the *Health Professions and Occupations Act*, for governing the designated health profession of medicine, or

(b) an accredited body recognized by the Board;

"psychologist" means a person who is authorized

(a) under the *Health Professions and Occupations Act* to practise the designated health profession of psychology, or

(b) under the laws of another province to practise as a psychologist;

…

POLICY

The complexity of mental disorders gives rise to challenges in the adjudication of a claim for a mental or physical condition that is described, at the time of diagnosis, in the most recent *Diagnostic and Statistical Manual of Mental Disorders* ("DSM") published by the American Psychiatric Association. The mental disorder may be the result of a number of contributing factors, some of which are work-related and some of which are not.

This policy provides guidance on the adjudication of claims for mental disorders where the mental disorder is either:

- a reaction to one or more traumatic events arising out of and in the course of the worker's employment; or

- predominantly caused by a significant work-related stressor, or a cumulative series of significant work-related stressors, arising out of and in the course of the worker's employment.

Section 135 of the *Act* sets out that a worker may be entitled to compensation for a mental disorder that does not result from an injury. This is distinct from a worker's entitlement under section 134(1) for psychological impairment that is a compensable consequence of an injury.

For decisions respecting the compensation or rehabilitation of a worker, the standard of proof under section 339(3) of the *Act* is "at least as likely as not." If the evidence supporting different findings on an issue is evenly weighted, the issue is resolved in favour of the worker.

This standard of proof is different than medical or scientific standards of certainty. Therefore, the presence or absence of expert evidence supporting or opposing a causal link is relevant and will generally be given weight by the Board, but it is not determinative of causation; causation can be inferred from other evidence. In every case, the Board decides whether the evidence supports a finding of causation based on a weighing of the evidence.

The gathering and weighing of evidence generally is covered by policy in Items C12-97.00 through C12-97.50.

A. Does the worker have a DSM diagnosed mental disorder?

Section 135 requires more than the normal reactions to traumatic events or significant work-related stressors, such as being dissatisfied with work, upset or experiencing distress, frustration, anxiety, sadness or worry as those terms are widely and informally used.

It requires that a worker's mental disorder be diagnosed by a psychiatrist or a psychologist as a condition that is described in the most recent DSM, at the time of diagnosis.

As set out in the DSM, a DSM diagnosis generally involves a comprehensive and systematic clinical assessment of the worker.

The Board is responsible for the decision-making process, and for reaching the conclusions on the claim. Under section 135(3) of the *Act*, the Board may obtain expert

advice to review the diagnosis and where required, may obtain additional diagnostic assessment.

In reviewing the diagnosis, the Board also considers all of the relevant medical evidence, including prior medical history, attending physician reports and expert medical opinion. The findings of this additional information are considered in determining whether there is a DSM diagnosed mental disorder.

B. Was there one or more events, or a stressor, or a cumulative series of stressors?

In all cases, the one or more events, stressor or cumulative series of stressors, must be identifiable.

C. Was the event "traumatic" or the work-related stressor "significant"?

All workers are exposed to normal pressures and tensions at work which are associated with the duties and interpersonal relations connected with employment.

A "traumatic" event is an emotionally shocking event. In most cases, the worker must have experienced or witnessed the traumatic event.

A work-related stressor is considered "significant" when it is excessive in intensity and/or duration from what is experienced in the normal pressures or tensions of employment.

Interpersonal conflicts between the worker and their supervisors, co-workers or customers are not generally considered significant unless the conflict results in behaviour that is considered threatening or abusive.

As set out in the *Act*, an example of a significant work-related stressor includes exposure to workplace bullying or harassment.

The Board recognizes that workers may, due to the nature of their work, be exposed to traumatic events or significant work-related stressors as part of their employment. An event may be traumatic or a work-related stressor significant even though the worker has previous work-related exposure to traumatic events or significant stressors.

In determining whether an event is traumatic or a work-related stressor is significant, the worker's subjective statements and response to the event or work-related stressor are considered. However, this question is not determined solely by the worker's subjective belief about the event or work-related stressor. It involves an analysis of both subjective and objective factors. The Board considers whether a reasonable person, in the worker's situation and with the general characteristics of the worker, would expect to find the event traumatic or the work-related stressor significant.

D. Causation

(i) Was the mental disorder a reaction to one or more traumatic events arising out of and in the course of the worker's employment?

The *Act* requires that the mental disorder be a reaction to one or more traumatic events arising out of and in the course of the worker's employment. This requires the Board to determine the following:

- Did the one or more traumatic events arise in the course of the worker's employment?

  This refers to whether the one or more traumatic events happened at a time and place and during an activity consistent with, and reasonably incidental to, the obligations and expectations of the worker's employment.

- Did the one or more traumatic events arise out of the worker's employment?

  This refers to the cause of the mental disorder. Both employment and non-employment factors may contribute to the mental disorder. However, in order for the mental disorder to be compensable, the one or more traumatic events have to be of causative significance, which means more than a trivial or insignificant cause of the mental disorder.

In making the above determinations, the Board reviews the medical and non-medical evidence to consider whether:

- there is a connection between the mental disorder and the one or more traumatic events, including whether the one or more traumatic events were of sufficient degree and/or duration to be of causative significance in the mental disorder;

- any pre-existing non-work related medical conditions were a factor in the mental disorder; and

- any non-work related events were a factor in the mental disorder.

The Board is required to determine whether the evidence supports a finding of one or more traumatic events that are of causative significance in the mental disorder.

(ii) Was the mental disorder predominantly caused by a significant work-related stressor, or a cumulative series of significant work-related stressors, arising out of and in the course of the worker's employment?

The *Act* requires that the mental disorder be predominantly caused by a significant work-related stressor, or a cumulative series of significant work-related stressors,

arising out of and in the course of the worker's employment. There are two parts to this requirement as set out below.

The first part is the determination of whether the significant stressor or cumulative series of significant stressors arose out of and in the course of employment. This requires the Board to determine the following:

- Did the significant stressor or cumulative series of significant stressors arise in the course of the worker's employment?

  This refers to whether the significant stressor, or cumulative series of significant stressors, happened at a time and place and during an activity consistent with, and reasonably incidental to, the obligations and expectations of the worker's employment.

- Did the significant stressor or cumulative series of significant stressors arise out of the worker's employment?

  A significant stressor or a cumulative series of significant stressors may be due to employment or non-employment factors. The *Act* requires that the significant stressors be work-related.

The second part is the determination of whether the significant work-related stressor, or cumulative series of significant work-related stressors, was the predominant cause of the mental disorder.

Predominant cause means that the significant work-related stressor, or cumulative series of significant work-related stressors, was the primary or main cause of the mental disorder.

Both parts of this requirement must be met in order for the mental disorder to be compensable.

(iii) Pre-existing Mental Disorders

Where a worker has a pre-existing mental disorder and claims that a traumatic event or significant work-related stressor aggravated the pre-existing mental disorder, the claim is adjudicated with regard to section 135 of the *Act* and the direction in this policy.

E. Section 135(1)(c) Labour Relations Exclusion

Section 135(1)(c) provides there is no entitlement to compensation if the mental disorder is caused by a decision of the worker's employer relating to the worker's employment. This exclusion is to ensure employers remain able to manage their workplaces and workers in an effective manner.

The labour relations exclusion is not absolute. It only applies to employer decisions on generic processes and actions taken in good faith. This means an employer decision must be both:

- on a generic process; and
- made and performed in good faith.

Decisions of the employer are not limited to explicit decisions and include circumstances related to the worker's employment over which the employer has control.

The *Act* provides a list of examples of decisions on generic processes relating to a worker's employment which include a decision to change the work to be performed or the working conditions, to discipline the worker or to terminate the worker's employment. This statutory list of examples is inclusive and not exclusive.

Other examples of decisions on generic processes relating to a worker's employment may include decisions relating to workload and deadlines, work evaluation, performance management, transfers, changes in job duties, lay-offs, demotions and reorganizations.

For the purpose of this policy, good faith is the absence of bad faith. Bad faith means improper purpose or ulterior motive, or a misuse of managerial authority. Bad faith is not simply bad judgment. Decisions performed in bad faith would include management decisions communicated to the worker in an abusive or threatening manner.

Determining whether the labour relations exclusion applies to an employer's decision requires an objective analysis. It does not turn on the worker's subjective perceptions or opinions of the employer's decision or motivation. The Board considers how a reasonable person would view the employer's conduct.

EFFECTIVE DATE:	March 2, 2026
AUTHORITY:	Section 135 of the *Act.*
CROSS REFERENCES:	*Rehabilitation Services & Claims Manual*, Volume II: Item C3-24.10, *Section 135(2) – Mental Disorder Presumption*; Item C3-22.30, *Compensable Consequences – Psychological Impairment*; Item C12-97.00, *Evidence – General*; Item C12-97.10, *Evidence Evenly Weighted*; Item C12-97.20, *Presumptions*; Item C12-97.30, *Medical Evidence*; Item C12-97.40, *Evidence – Other Matters*; Item C12-97.50, *Surveillance.*
HISTORY:	April 1, 2026 – Housekeeping changes to the Background section resulting from the replacement of the *Health Professions Act* with the *Health Professions and Occupations Act*.

March 2, 2026 − Amended the definition of significant work-related stressor; guidance provided on the British Columbia Supreme Court's reading down of the labour relations exclusion to ensure compliance with section 15(1) of the *Canadian Charter of Rights and Freedoms*.
December 1, 2025 − Housekeeping change to update internal cross-references, consequential to reformatting and renumbering Chapter 12, *Claims Procedures.*
June 1, 2024 − Housekeeping changes made to modernize terminology by removing gendered language.
October 21, 2020 − Housekeeping amendments to the *Act* portion of the Background section to reflect amendments to the *Act* by the *Workers Compensation Amendment Act*, *2020* (Bill 23 of 2020), in effect August 14, 2020.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
February 1, 2020 − Policy amended to provide guidance on the legal issues of standard of proof, evidence, and causation.
May 16, 2019 – the *Workers Compensation Amendment Act*, *2019* (Bill 18 of 2019) amended the definition of firefighter in sections 1 and 5.1 of the then *Workers Compensation Act*, R.S.B.C. 1996, c. 492. Bill 18 of 2019 was brought into force on May 16, 2019, the transitional provisions in sections 4 and 5 of the Bill set out how the legislative amendments apply to claims made before May 16, 2019.
March 1, 2019 − Consequential amendments arising from addition of then policy item #97.70, *Surveillance* were made.
July 23, 2018 – Amendments to Item C3-13.00 were made to reflect changes to the *Act* resulting from the *Workers Compensation Amendment Act, 2018* (Bill 9 of 2018). Bill 9 of 2018 added a mental disorder presumption to the then *Workers Compensation Act*, R.S.B.C. 1996, c. 492, for workers who are or have been employed in an eligible occupation, and revised the definition of firefighter in then section 5.1 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, to include firefighters employed by the government of Canada. Bill 9 of 2018 was brought into force on May 17, 2018, the transitional provisions in sections 3 and 4 of the Bill set out how the legislative amendments apply to claims made before May 17, 2018.
January 1, 2018 − Housekeeping changes were made to the definition of "psychologist" as amended by the *Act* effective November 2, 2017.
July 17, 2013 − Housekeeping changes were made to remove references to multi-axial diagnostic assessment in accordance with DSM-5.
July 1, 2012 – New Item C3-13.00, *Section 5.1 – Mental Disorders*, was added, to reflect changes to the *Act* resulting from the *Workers Compensation Amendment Act, 2011* (Bill 14 of 2011). This section of Bill 14 of 2011 came into force on January 1, 2012, the transitional provision in section 5 of the Bill set out how the legislative amendment applies to claims made before January 1, 2012. This policy replaced former Item C3-13.00, *Mental Stress*, of the *Rehabilitation Services & Claims Manual*, Volume II, in its entirety. Former Item C3-13.00 had replaced former policy item #13.30 by putting it into the new format.
April 30, 2009 – Former policy item #13.30 was amended to delete references identified by the British Columbia Court of Appeal as being

contrary to section 15(1) of the *Canadian Charter of Rights and Freedoms*.

April 1, 2007 – Former policy item #13.30 was amended to delete the paragraph requiring workers with a recurrence of mental stress to meet the requirements of then section 5.1, if their claims had initially been allowed prior to June 30, 2002.

December 31, 2003 – Former policy item #13.30 was amended to reflect the amendment of then section 5.1(1) of the *Act*, to include a reference to a psychologist's diagnosis of mental stress, and the introduction of then sections 5.1(2) to (4) of the *Act*. The amended policy applied to acute reactions to traumatic events that occurred on or after December 31, 2003. Former policy item #13.30 had been created on June 30, 2002 to set out the scope of coverage for mental stress claims. It applied to all injuries on or after June 30, 2002; permanent disabilities where the permanent disability first occurred on or after June 30, 2002, irrespective of the date of the injury; and recurrences, where the recurrence occurred on or after June 30, 2002, irrespective of the date of the injury.

APPLICATION: Applies to all decisions, including appellate decisions, made on or after March 2, 2026.

RE:	Section 135(2) – Mental Disorder Presumption	ITEM:	C3-24.10

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the adjudication of claims for a mental disorder where the presumption in section 135(2) of the *Act* applies.

2. The Act

Section 1, in part:

> **"firefighter"** means a member of a fire brigade, working with or without remuneration, who is assigned primarily to
>
> (a) fire suppression duties, whether or not those duties include the performance of ambulance or rescue services,
>
> (b) investigation duties respecting the cause, origin or circumstances of a fire, or
>
> (c) any combination of both fire suppression duties as described in paragraph (a) and fire investigation duties as described in paragraph (b);
>
> …

Section 135, in part:

> (1) Subject to subsection (3), a worker is entitled to compensation for a mental disorder, payable as if the mental disorder were a personal injury arising out of and in the course of a worker's employment, if that mental disorder does not result from an injury for which the worker is otherwise entitled to compensation under this Part, and only if…
>
> ...
>
> (b) the mental disorder is diagnosed by a psychiatrist or psychologist as a mental or physical condition that is described, at the time of diagnosis, in the most recent Diagnostic and Statistical Manual of

Mental Disorders published by the American Psychiatric Association;

…

(2) If a worker who is or has been employed in an eligible occupation

(a) is exposed to one or more traumatic events arising out of and in the course of the worker's employment in that eligible occupation, and

(b) has a mental disorder that, at the time of diagnosis under subsection (1)(b), is recognized in the manual referred to in that subsection, as a mental or physical condition that may arise from exposure to a traumatic event,

the mental disorder must be presumed to be a reaction to the one or more traumatic events arising out of and in the course of the worker's employment in that eligible occupation, unless the contrary is proved.

(3) The Board may require that a psychiatrist or psychologist appointed by the Board review a diagnosis made for the purposes of subsection (1)(b) and may consider that review in determining whether a worker is entitled to compensation for a mental disorder.

(4) Section 163 *[duties of physicians and qualified practitioners]* applies to a psychiatrist or psychologist who makes a diagnosis referred to in this section.

(5) In this section:

"correctional officer" means a correctional officer as defined by regulation of the Lieutenant Governor in Council;

"eligible occupation" means the occupation of correctional officer, emergency medical assistant, firefighter, police officer, sheriff or, without limitation, any other occupation prescribed by regulation of the Lieutenant Governor in Council;

"emergency medical assistant" means an emergency medical assistant as defined in section 1 of the *Emergency Health Services Act*;

"police officer" means an officer as defined in section 1 of the *Police Act*;

"psychiatrist" means a physician who is authorized to practise in the speciality of psychiatry by

(a) the regulator that is responsible, under the *Health Professions and Occupations Act*, for governing the designated health profession of medicine, or

(b) an accredited body recognized by the Board;

"psychologist" means a person who is authorized

(a) under the *Health Professions and Occupations Act* to practise the designated health profession of psychology, or

(b) under the laws of another province to practise as a psychologist;

"sheriff" means a person lawfully holding the office of sheriff or lawfully performing the duties of sheriff by way of delegation, substitution, temporary appointment or otherwise.

3. Mental Disorder Presumption Regulation

Section 1:

(1) For the purposes of section 135(5) *[mental disorder]* of the *Workers Compensation Act*, **"correctional officer"** means a worker who

(a) is employed in a correctional centre, as defined in the *Correction Act*, and is appointed under section 2(1)(b) of that Act,

(b) is employed in a youth custody centre, as defined in the *Youth Justice Act*, and is appointed under section 24(1)(b) of that Act, or

(c) is employed in a penitentiary, as defined in the *Corrections and Conditional Release Act* (Canada), and holds one of the following positions:

(i) warden;

(ii) deputy warden;

(iii) assistant warden of operations;

(iv) correctional manager;

(v) correctional officer, including a correctional officer who holds the position of primary worker.

Section 2:

The following occupations, as defined in the Schedule, are prescribed as eligible occupations for the purposes of section 135(5) of the *Workers Compensation Act*:

(a) community integration specialist;

(b) coroner;

(c) emergency response dispatcher;

(d) harm reduction worker;

(e) health care assistant;

(f) nurse;

(g) parole officer;

(h) probation officer;

(i) respiratory therapist;

(j) shelter worker;

(k) social worker;

(l) transition house worker;

(m) victim service worker;

(n) withdrawal management worker.

Schedule:

1 In this regulation:

"community integration specialist" means a worker

(a) who is appointed under the *Public Service Act,*

(b) whose duties include supporting persons in relation to

(i) income assistance or disability assistance, or

(ii) accessing support services for trauma, mental illness or addiction, and

(c) who works primarily in one or more of the following:

(i) a correctional centre, youth custody centre or penitentiary referred to in section 1(1) of this regulation;

(ii) a site operated by a board as defined in section 1 of the *Health Authorities Act*;

(iii) an emergency shelter or homeless encampment;

(iv) a community-based location;

"coroner" means a worker

(a) who is appointed as a coroner under section 54 of the *Coroners Act*, or

(b) who is retained to act as a coroner under section 55 of the *Coroners Act*;

"emergency response dispatcher" means a worker whose duties include one or both of the following:

(a) dispatching ambulance services, firefighters or police officers;

(b) receiving emergency calls that initiate the dispatch of ambulance services, firefighters or police officers;

"harm reduction worker" means a worker

(a) whose duties include, for the purpose of reducing the risk of toxic drug poisoning and other drug-related harms, supporting and monitoring persons who consume drugs, and

(b) who works primarily in one or more of the following:

(i) the community;

(ii) residential facilities or units in which supportive housing services are provided;

(iii) premises used to provide public health interventions, including sites

(A) commonly known as safe consumption sites, or

(B) at which other types of overdose prevention services are provided;

"health care assistant" means a worker

(a) who is registered with the BC Care Aide & Community Health Worker Registry, and

(b) who is employed as a health care assistant in a publicly funded organization or setting;

"nurse" means a worker who is authorized under the *Health Professions and Occupations Act* to practise the designated health profession of licensed practical nursing, nursing or psychiatric nursing;

"parole officer" means a worker who holds the position of parole supervisor within the meaning of section 99(1) of the *Corrections and Conditional Release Act* (Canada);

"probation officer" means a worker who is appointed under one of the following:

(a) section 2(1)(a) of the *Correction Act*;

(b) section 2(1)(b) of the *Correction Act*, for the purpose of exercising powers and performing duties as a probation officer;

(c) section 24(1)(a) of the *Youth Justice Act*;

(d) section 24(1)(b) of the *Youth Justice Act*, for the purpose of exercising powers and performing duties as a youth probation officer;

"respiratory therapist" means a worker whose duties include assisting health professionals in evaluating, diagnosing, treating and caring for patients with respiratory or cardiopulmonary disorders;

"shelter worker" means a worker

(a) who works at a shelter for persons experiencing homelessness, and

(b) whose duties include the provision of one or more of the following:

(i) intake services;

(ii) supporting and monitoring residents with respect to well-being and safety;

"social worker" means a worker who is authorized, under the *Social Workers Act*, to use the title "social worker";

"transition house worker" means a worker

(a) who is employed in a facility that provides housing to persons who have recently left abusive relationships, and to their children, if any, and

(b) whose duties include providing support, security and crisis intervention to one or both of the following:

(i) residents of the facility;

(ii) crisis line callers;

"victim service worker" means a worker who assists victims through a victim service within the meaning of the *Victims of Crime Act*;

"withdrawal management worker" means a worker whose duties include assessing, supervising, monitoring and stabilizing chemically-dependent persons during acute detoxification from substance use.

POLICY

Section 135(2) of the *Act* provides a mental disorder presumption. The presumption applies where a worker is:

- exposed to one or more traumatic events arising out of and in the course of the worker's employment in an eligible occupation; and

- diagnosed by a psychiatrist or psychologist with a mental disorder that is recognized in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association ("DSM") as a mental or physical condition that may arise from exposure to a traumatic event.

Where the mental disorder presumption does not apply, a worker's claim for compensation for a mental disorder will be adjudicated under section 135 of the *Act.*

A. What is an eligible occupation?

The mental disorder presumption applies to a worker who is or has been employed in an eligible occupation as defined in the *Act* or prescribed by regulation of the Lieutenant Governor in Council.

B. Was the worker exposed to a "traumatic" event?

The *Act* requires the worker is exposed to one or more traumatic events. In all cases, the one or more events must be identifiable.

A "traumatic" event is an emotionally shocking event. In most cases, the worker must have experienced or witnessed the traumatic event.

The Board recognizes that workers employed in eligible occupations, due to the nature of their work, may be exposed to traumatic events as part of their employment.

In determining whether the event is traumatic the worker's subjective statements and response to the event are considered. However, this question is not determined solely by the worker's subjective belief about the event. It involves both a subjective and objective analysis. The Board considers whether a reasonable person, in the worker's situation and with the general characteristics of the worker, would expect to find the event traumatic.

C. DSM diagnosis

The *Act* requires the worker's mental disorder be diagnosed by a psychiatrist or a psychologist. At the time of diagnosis, the worker's mental disorder must be described in the most recent DSM, and that DSM must also recognize the mental disorder as a mental or physical condition that may arise from exposure to a traumatic event.

In reviewing the diagnosis, the Board recognizes a broad range of mental disorders may arise following exposure to a traumatic event. Some mental disorders recognized in the DSM explicitly list exposure to a traumatic event as a diagnostic criterion. This means exposure to a traumatic event is required for the diagnosis, for example post-traumatic stress disorder and acute stress disorder.

The Board also recognizes there are mental disorders set out in the DSM that do not require exposure to a traumatic event but may still arise from trauma. These include, but are not limited to, depressive disorders, anxiety disorders and substance use disorders.

D. Causation

The *Act* requires that the mental disorder be presumed to be a reaction to the one or more traumatic events arising out of and in the course of the worker's employment in that eligible occupation, unless the contrary is proved.

The Board is not required to establish that any specific traumatic event is causative of the worker's mental disorder.

E. Rebutting the presumption

Inclusion of the words "unless the contrary is proved" in section 135(2) means that the presumption is rebuttable. Where evidence which rebuts or refutes the presumption is available, it must be considered.

The standard of proof to be applied in determining whether the presumption has been rebutted is proof on a balance of probabilities. Balance of probabilities means "more likely than not." If the evidence is more heavily weighted in favour of a conclusion that something other than the employment caused the mental disorder, then the contrary will be considered to be proved and the presumption is rebutted. The presumption is not rebutted because there is a lack of evidence to support work causation.

The gathering and weighing of evidence generally is covered by policy in Items C12-97.00 through C12-97.50.

F. Pre-existing mental disorders

Where a worker who is or has been employed in an eligible occupation has a pre-existing mental disorder and claims that a traumatic event aggravated the pre-existing mental disorder, the claim is adjudicated with regard to section 135(2) of the *Act* and the direction in this policy.

For the presumption to apply, the pre-existing mental disorder must also be recognized in the most recent DSM as a mental or physical condition that may arise from exposure to a traumatic event.

EFFECTIVE DATE:	March 2, 2026
AUTHORITY:	Sections 1 and 135 of the *Act.*
CROSS REFERENCES:	*Rehabilitation Services & Claims Manual*, Volume II: Item C3-24.00, *Section 135 – Mental Disorders*; Item C3-22.30, *Compensable Consequences – Psychological Impairment*; Item C12-97.00, *Evidence – General*; Item C12-97.10, *Evidence Evenly Weighted*;

Item C12-97.20, *Presumptions*;
Item C12-97.30, *Medical Evidence*;
Item C12-97.40, *Evidence – Other Matters*;
Item C12-97.50, *Surveillance.*

HISTORY:

April 1, 2026 – Housekeeping changes to the Background section resulting from the replacement of the *Health Professions Act* with the *Health Professions and Occupations Act*.
March 2, 2026 − Policy amended to provide guidance on the meaning of a subjective and objective analysis when determining whether an event is traumatic.
December 1, 2025 − Housekeeping change to update internal cross-references, consequential to reformatting and renumbering Chapter 12, *Claims Procedures.*
June 10, 2024 − Housekeeping changes consequential to the approval of Order in Council No. 299, which added additional eligible occupations to the *Mental Disorder Presumption Regulation* (B.C. Reg. 122/2024, deposited June 10, 2024).
October 21, 2020 − Housekeeping amendments to the *Act* portion of the Background section to reflect amendments to the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
February 1, 2020 − Policy amended to provide guidance on the legal issues of standard of proof, evidence, and causation.
May 16, 2019 – the *Workers Compensation Amendment Act, 2019* (Bill 18 of 2019) amended the definition of firefighter in sections 1 and 5.1 of the then *Workers Compensation Act*, R.S.B.C. 1996, c. 492. Bill 18 of 2019 was brought into force on May 16, 2019, the transitional provisions in sections 4 and 5 of the Bill set out how the legislative amendments apply to claims made before May 16, 2019.
April 16, 2019 – This policy was amended when Order in Council No. 204 was approved, adding emergency response dispatchers, health care assistants, and nurses to the list of eligible occupations (B.C. Reg. 92/2019, deposited April 16, 2019).
March 1, 2019 − Consequential amendments were made arising from addition of then policy item #97.70, *Surveillance*.
July 23, 2018 – New Item C3-13.10, *Section 5.1(1.1) – Mental Disorder Presumption,* was added to reflect changes to the *Act* resulting from the *Workers Compensation Amendment Act, 2018* (Bill 9 of 2018). Bill 9 of 2018 added a mental disorder presumption to the then *Workers Compensation Act*, R.S.B.C. 1996, c. 492, for workers who are or have been employed in an eligible occupation, and revised the definition of firefighter in then section 5.1 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, to include firefighters employed by the government of Canada. Bill 9 of 2018 was brought into force on May 17, 2018, the transitional provisions in sections 3 and 4 of the Bill set out how the legislative amendments apply to claims made before May 17, 2018.

APPLICATION:

Applies to all decisions, including appellate decisions, made on or after March 2, 2026.

RE: Occupational Disease **ITEM: C4-25.00**

BACKGROUND

1. Explanatory Notes

This policy sets out the legislative requirements for compensation for occupational disease.

2. The Act

Section 136:

(1) Compensation is payable under this Part [Part 4 − Compensation to Injured Workers and Their Dependants] in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment, if

(a) as applicable,

(i) the worker has an occupational disease that disables the worker from earning full wages at the work at which the worker was employed, or

(ii) the death of the worker is caused by an occupational disease, and

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

(2) For the purposes of subsection (1), the date of disablement must be treated as the occurrence of the injury.

(3) A health care benefit may be provided for a worker who has an occupational disease referred to in subsection (1)(b) even though the worker is not disabled from earning full wages at the work at which the worker was employed.

Section 145:

(1) A worker is entitled to compensation under this Part [Part 4 – Compensation to Injured Workers and Their Dependants] if

(a) the worker has a hearing loss of non-traumatic origin that arose out of and in the course of employment to which the compensation provisions apply, and

(b) the hearing loss

(i) was sustained by exposure to causes of hearing loss in British Columbia, and

(ii) is a greater loss than the minimum set out in Schedule 2 *[Non-Traumatic Hearing Loss]* of this Act.

(2) An application for compensation under this section must be accompanied or supported by a specialist's report and audiogram or by other evidence of hearing loss that the Board prescribes.

(3) The Board may, by regulation, amend Schedule 2 in respect of the following:

(a) the ranges of hearing loss;

(b) the percentages of disability, including the maximum percentages of total disability;

(c) the methods or frequencies to be used to measure hearing loss.

POLICY

A. INTRODUCTION

Section 136 of the *Act* provides that compensation is payable for occupational disease that is due to the nature of a worker's employment. Section 145 provides that compensation is payable for a certain level of non-traumatic noise-induced hearing loss that results from a worker's employment. A worker's entitlement to compensation for a total or partial disability resulting from a hearing loss is paid in accordance with the compensation provisions set out in Division 6 of Part 4 of the *Act*.

Most compensation cases involve a personal injury (covered in Chapter 3) where it can readily be determined whether the event or series of events leading to such injury arose out of and in the course of a worker's employment. The cause of disease, by its nature, is often more difficult to determine. A common difficulty is distinguishing between an injury and a disease (the difference is discussed in Item C3-12.00). Even when medical science has identified the cause of a disease in a general sense, it may be difficult to establish with any degree of certainty how and when a worker contracted or developed a disease. Further, workers' compensation does not extend to all diseases, rather only

to those that are due to a worker's employment. In these circumstances, determining the extent to which a worker's employment had a role in producing the disease becomes a critical or central issue.

The question is: was the worker's disability caused by the worker's work or by something else such as the operation of natural causes, or by congenital or hereditary disease. The *Act* provides different ways of dealing with this issue. These are discussed in Chapter 4 of this *Manual*.

B. LEGISLATIVE REQUIREMENTS

For the diseases to which section 136 of the *Act* applies, there are three basic requirements for compensability:

1. The worker must have (or in the case of a deceased worker have had) a disease designated or recognized by the Board as an "occupational disease";

2. The worker's occupational disease must be or have been "due to the nature of any employment" in which the worker was employed; and

3. The occupational disease must "disable the worker from earning full wages at the work" at which the worker was employed. In the case of a deceased worker, the worker's death must have been caused by such occupational disease. This is discussed further in Item C4-25.30. This third requirement does not apply to claims for silicosis, asbestosis, or pneumoconiosis (see Item C4-29.10) or to claims for non-traumatic noise-induced hearing loss to which section 145 of the *Act* applies. Further, a worker need not be disabled by the occupational disease in order to be entitled to health care benefits.

These elements of section 136 are discussed further in Items C4-25.10, C4-25.20, and C4-25.30. The definition of "worker" is covered in Chapter 2.

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

EFFECTIVE DATE: April 6, 2020
AUTHORITY: Sections 136 and 145 of the *Act.*
CROSS REFERENCES: Item C3-12.00, *Personal Injury*;
Item C4-25.10, *Has a Designated or Recognized Occupational Disease*;
Item C4-25.20, *Establishing Work Causation*;
Item C4-25.30, *Disabled from Earning Full Wages at Work*;

Item C4-29.10, *Pneumoconioses and Other Specified Diseases of the Lungs*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY: November 24, 2022 – Housekeeping changes consequential to implementing the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41).
April 6, 2020 – This policy resulted from the consolidation of former policy items #25.00 and #25.10 of the *Rehabilitation Services & Claims Manual*, Volume II, consequential to the implementation of the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

APPLICATION: This Item applies to all decisions, including appellate decisions, made on or after April 6, 2020.

RE:	Has a Designated or Recognized Occupational Disease	ITEM:	C4-25.10

BACKGROUND

1. Explanatory Notes

This policy provides guidance for determining whether a worker has a disease designated or recognized as an "occupational disease".

2. The Act

Section 1, in part:

> **"occupational disease"** means a disease, including a disablement resulting from exposure to contamination, that is
>
> (a) a disease identified in Schedule 1 *[Presumption of Occupational Disease Related to Specific Process or Industry]* of this Act,
>
> (b) a disease designated or recognized by regulation under section 138(2) *[Board regulation of general application]*,
>
> (c) a disease designated or recognized by order under section 138(3) *[Board order in specific case]*,
>
> (d) a disease designated or recognized under section 138(4) *[disease peculiar to or characteristic of particular employment]*, or
>
> (e) a disease
>
> (i) referred to in section 139(2) *[firefighters: presumptions respecting heart disease]*,
>
> (ii) referred to in section 140(1)(a) *[firefighters: presumptions respecting primary site lung cancer]*, or
>
> (iii) prescribed by regulation of the Lieutenant Governor in Council for the purposes of section 140(1)(b) *[firefighters: presumptions respecting prescribed diseases]*,
>
> but only in respect of a worker to whom the presumption in any of those provisions applies, unless the disease is otherwise described by this definition;

...

Section 136(1):

(1) Compensation is payable under this Part in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment, if

(a) as applicable,

(i) the worker has an occupational disease that disables the worker from earning full wages at the work at which the worker was employed, or

(ii) the death of the worker is caused by an occupational disease, and

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

Section 138:

(1) The Board may, by regulation, do the following:

(a) add to or delete from Schedule 1 of this Act a disease that, in the opinion of the Board, is an occupational disease;

(b) add to or delete from that Schedule a process or an industry;

(c) set terms, conditions and limitations for the purposes of paragraphs (a) and (b) of this subsection.

(2) The Board may, by regulation of general application, designate or recognize a disease as an occupational disease.

(3) The Board may, by order, designate or recognize a disease as an occupational disease in a specific case.

(4) The Board may designate or recognize a disease as being a disease that is peculiar to or characteristic of a particular process, trade or occupation, on the terms and conditions and with the limitations set by the Board.

POLICY

A. HAS AN OCCUPATIONAL DISEASE DESIGNATED OR RECOGNIZED BY THE BOARD

Part of the first requirement for compensability is that the worker has, or in the case of a deceased worker the death was caused by, a disease designated or recognized by the Board as an "occupational disease".

For decisions respecting the compensation or rehabilitation of a worker, the standard of proof under section 339(3) of the *Act* is "at least as likely as not." This standard is different than medical or scientific standards of certainty. Confirming the diagnosis of many occupational diseases may be difficult. This is particularly so for poisoning by some of the metals and compounds listed in Schedule 1, the symptoms of which may be similar to the symptoms caused by common complaints that produce fatigue, nausea, headache and the like. Evidence that an occupational disease has been diagnosed is relevant and will generally be given significant weight by the Board, but it is not a requirement under section 136(1) of the *Act*. The question for the Board is whether it is "at least as likely as not" that the worker has or the deceased worker's death was caused by, an occupational disease designated or recognized by the Board as an "occupational disease".

In one Board decision, a worker was advised by the attending physician that he had lead poisoning and should temporarily withdraw from work. The Board concurred with that advice. Laboratory testing done one month later led to a conclusion that initial tests had been wrong and that the worker never did have lead poisoning. The Board concluded that in these circumstances, where the worker acted reasonably in reliance on medical advice that the Board agreed with, the merits and justice of the claim warranted a conclusion that the worker had an occupational disease at the time in question even though in retrospect this was proven not to be the case. The cost of compensation paid on a claim of this type is excluded from the employer's experience rating (see Item C17-114.10).

B. THE DESIGNATION OR RECOGNITION OF AN OCCUPATIONAL DISEASE

There are a great many diseases to which the general public are subject, many of which can be considered ordinary diseases of life. Available medical and scientific understanding about the causes of disease and about the role that employment may play covers a wide range from very good to very poor. Not every disease contracted by every worker is compensable. Deciding when they are is key to the operation of the *Act* and to adjudicating individual disease claims. It is within this context that decisions must be made as to the compensability of diseases that workers who are covered by the *Act* may have.

To assist in adjudicating the merits of occupational disease claims, to facilitate efficiency and consistency in the decision-making process and to establish an institutional memory (with the additional benefit of providing the working community with confirmation that the Board is aware that a disease may arise as a result of employment activities), the *Act* provides a means by which the Board may designate or recognize a disease as an "occupational disease".

There are levels of designation or recognition based on the available medical and scientific evidence and on the Board's experience in dealing with these diseases. The manner in which a disease is designated or recognized is primarily based on the strength of medical and scientific knowledge about the role employment may have in its causation. The following are the various ways in which an occupational disease may be designated or recognized:

- by inclusion in Schedule 1;
- by regulation of general application;
- by order dealing with a specific case; or
- under section 138(4), as being a disease that is peculiar to or characteristic of a particular process, trade or occupation, on the terms and conditions and with the limitations set by the Board.

The highest level of designation or recognition is by addition of a disease to Schedule 1, under section 138(1). It is important to distinguish between this kind of disease designation or recognition and the designation or recognition of an occupational disease under section 138(2), where an occupational disease is designated or recognized by regulation of general application, or under section 138(4), where a particular process, trade or occupation is specified in the designation or recognition.

If the Board concludes that a disease is more likely to occur in connection with a particular employment covered by the *Act* than elsewhere, it may be added to Schedule 1. On the other hand, if the Board concludes that a disease is only sometimes due to the nature of a particular employment covered by the *Act*, and it does not appear that the disease is more likely to occur in connection with any particular employment than elsewhere (it is not something specific to that employment), the Board may designate or recognize the disease under section 138(2), by regulation of general application without the rebuttable presumption afforded by inclusion in Schedule 1.

If the Board concludes that a disease is only sometimes due to the nature of a particular employment covered by the *Act*, and has identified a particular process, trade, or occupation, the Board may so designate or recognize the disease under section 138(4).

If there is only weak or an absence of medical and scientific information causally associating a disease with employment, it will not be designated or recognized as an

occupational disease by inclusion in Schedule 1, by regulation of general application, or by the Board as being peculiar to or characteristic of a particular process, trade or occupation. In individual claims, however, the Board may recognize such a disease by order in a specific case under section 138(3).

The authority by regulation, to designate or recognize a disease under section 138(1) and under section 138(4) rests with the Board of Directors.

C. RECOGNITION BY INCLUSION IN SCHEDULE 1

Any disease listed in the first column of Schedule 1 is by definition designated or recognized as an occupational disease. This is the highest level of designation or recognition.

The Board lists a disease in Schedule 1 in connection with a described process or industry wherever it is satisfied from the expert medical and scientific advice it receives that there is a substantially greater incidence of the particular disease in a particular employment than there is in the general population. The questions to be addressed include: is the disease common in that particular employment, and not common amongst the general public? Is it something specific to the employment?

Schedule 1 is set out in Appendix 2. The application of Schedule 1 is covered in Section A. of Item C4-25.20. The amendment of Schedule 1 is covered by section 138(1) of the *Act* set out below.

i. Amending Schedule 1

Section 138(1) gives the Board substantial flexibility in its ability to add to or delete from the list of diseases designated or recognized in Schedule 1, and to impose whatever terms, conditions or limitations it considers appropriate in doing so. It has the same flexibility in its ability to add to or delete from the descriptions of process or industry set out in column 2 of Schedule 1.

Claims for all of the diseases in Schedule 1 will be considered in respect of such disease even if the worker was not employed in the process or industry described opposite to the disease in column 2 of Schedule 1, but without the benefit of the presumption set out in section 137(2) of the *Act*. See Section C. of Item C4-25.20.

D. RECOGNITION BY REGULATION OF GENERAL APPLICATION

The Board may designate or recognize a disease as an occupational disease "by regulation of general application" (section 138(2)). In these circumstances, the Board is satisfied from the expert medical and scientific advice it receives that there is a greater incidence of the particular disease than there is in the general population, but without connecting it to a particular employment or providing a rebuttable presumption that the occupational disease is due to the nature of any employment in which the worker was

employed. The Board has designated or recognized the following as occupational diseases by regulation of general application:

Bronchitis
Bursitis (other than the forms of bursitis mentioned in Item 13 of Schedule 1 of the *Act*)
Campylobacteriosis (diarrhea caused by Campylobacter)
Carpal Tunnel Syndrome
Chicken Pox
Cubital Tunnel Syndrome
Disablement from vibrations
Emphysema
Food poisoning
Giardia Lamblia Infestation
Head lice (Pediculosis Capitis)
Heart Disease
Hepatitis A
Herpes Simplex
Hypothenar Hammer Syndrome
Legionellosis
Lyme Disease
Meningitis
Mononucleosis
Mumps
Plantar Fasciitis
Radial Tunnel Syndrome
Red Measles (Rubeola)
Ringworm
Rubella
Scabies
Shigellosis
Staphylococci infections
Streptococci infections
Tendinopathy (other than the forms of tendinopathy mentioned in Item 14 of Schedule 1 of the *Act*), including:

- Epicondylopathy (lateral and medial)
- Stenosing Tenosynovitis (Trigger Finger)

Thoracic Outlet Syndrome
Toxoplasmosis
Typhoid
Vinyl Chloride induced Raynaud's Phenomenon
Whooping Cough
Yersiniosis

Several of the above contagious diseases are not likely to meet the section 136 requirement to be ". . . due to the nature of any employment in which the worker was employed . . ." except for hospital employees, or workers at other places of medical care.

E. RECOGNITION BY ORDER DEALING WITH A SPECIFIC CASE

The lack of prior designation or recognition by the Board of a disease as an occupational disease does not mean a claim for such disease will not be considered on its merits. Such disease may not have been previously designated or recognized due to weak or a complete absence of medical and scientific information which causally associates such disease with employment. If the merits and justice of an individual claim for such a disease warrant its recognition as an occupational disease, section 138(3) provides that the Board may, "by order, designate or recognize a disease as an occupational disease in a specific case".

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

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

The Board upon investigating an individual claim may find that the condition of the worker is not one listed in the first column of Schedule 1, nor is it one which has been previously designated or recognized by the Board as an occupational disease under section 138(2) by regulation of general application, or under section 138(4). If the Board concludes, after seeking appropriate input from both the worker (or the worker's legal representative) and the employer (if a specific employer is identified) that the facts warrant recognition of the worker's condition as an occupational disease, the Board officer will refer the claim with a recommendation to that effect to a panel made up of a Client Services Manager, (referred to in this policy as the "Manager", and a Board Medical Advisor (referred to in this policy as the "Medical Advisor").

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

The Manager, upon receipt of a recommendation from the Board officer for recognition of the worker's condition as an occupational disease, and after considering and discussing the claim with the Medical Advisor and after completing any further investigations which the Manager considers appropriate, will determine whether the condition reported is one which should be recognized by the Board as an occupational disease for the purposes of that claim. If so, the Manager will make an order to that effect which is recorded on the claim. The Manager will keep a record of all such referrals under section 138(3).

If, after considering a referral under this policy, the Manager concludes that the reported condition might not be recognized as an occupational disease, the worker (or in the case of a deceased worker, the worker's legal representative) will first be advised and provided with an opportunity to respond. A decision of the Manager not to recognize the condition as an occupational disease for the purposes of that claim is a reviewable decision.

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

Where the Manager is not the Client Services Manager, Occupational Disease Services, the Manager will ensure that the Client Services Manager, Occupational Disease Services is provided with written notice of any decisions under this section of this policy.

The designation or recognition of an occupational disease by inclusion in Schedule 1, or under section 138(2) by regulation of general application, does not preclude its recognition by order dealing with a specific case if the occupational disease occurred prior to its designation or recognition by one of the other alternate methods.

F. RECOGNITION UNDER SECTION 138(4)

Section 138(4) gives the Board substantial flexibility in its designation or recognition of an occupational disease.

The Board may designate or recognize a disease as being a disease that is peculiar to or characteristic of a particular process, trade or occupation with respect to future claims in a broad sense, or it may impose a much more limited designation or recognition by specifying whatever terms or conditions or limitations it deems appropriate.

Section 138(4) may be used to designate or recognize a disease where the expert medical and scientific information is insufficient to cause the Board to include it in Schedule 1 (with the benefit of the rebuttable presumption that the *Act* provides), but is sufficient to cause the Board to state for decision-makers (thus establishing an institutional memory) that there is a recognized possibility that the employment

contributed to the causation of the disease where the worker was employed in a specific process, trade, or occupation. In these circumstances there is no presumption that this is the case.

At this time, the Board does not recognize any diseases under this provision.

EFFECTIVE DATE:	April 6, 2020
AUTHORITY:	Section 138 of the *Act.*
CROSS REFERENCES:	Item C4-25.20, *Establishing Work Causation*; Item C17-114.10, *Investigation Costs*; Appendix 2, Schedule 1, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – Housekeeping change to update internal cross-reference, consequential to reformatting and renumbering Chapter 17, *Charging of Claim Costs*. April 6, 2020 – This policy resulted from the consolidation of former policy items #26.00, #26.01, #26.02, #26.03, #26.04, #26.10, and #26.60, consequential to the implementation of the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. The example in Section A. is derived from *Workers Compensation Reporter* Series Decision No. 3, (1973) 1 W.C.R. 11. February 1, 2020 – Former policy item #26.10 was amended to provide guidance regarding the legal issues of standard of proof and evidence. May 1, 2017 – Former policy item #26.00 was updated to add a reference to the firefighters' presumption in the definition of "occupational disease". Former policy item #26.60 was consequentially amended to reflect renumbering of former policy item #26.23. March 1, 2015 – Former policy item #26.03 had terminology updated by replacing tendinitis/tenosynovitis and epicondylitis with tendinopathy and epicondylopathy, which encompass both inflammatory and degenerative conditions. Stenosing tenovaginitis (trigger finger) replaced with stenosing tenosynovitis (trigger finger) based on the current medical science. Former policy item #26.04 had language added stating that an occupational disease may be recognized by regulation of general application, as well as to add flexibility for another WorkSafeBC officer, such as a Case Manager, to communicate with a worker when a reported condition might not be recognized as an occupational disease, and to add policy item titles; December 11, 2013 – Former policy item #26.02 was changed to remove reference to *Workers Compensation Reporter* series Decision No. 231, (1977) 3 W.C.R. 87 and reflect the current medical/scientific evidence regarding osteoarthritis of the first carpo-metacarpal joint of both thumbs in physiotherapists. June 1, 2009 – Former policy item #26.04 deleted references to Board officers. October 1, 2007 – Former policy item #26.04 was revised to delete references to memos and memorandums. March 3, 2003 – Former policy item #26.04 had consequential changes as to references to review. July 16, 2002 – Former policy item #26.02 was revised to reflect section numbering changes in the *Act* at the time, and housekeeping changes.
APPLICATION:	This Item applies to all decisions, including appellate decisions, made on or after April 6, 2020.

RE: Establishing Work Causation	ITEM: C4-25.20

BACKGROUND

1. Explanatory Notes

This policy sets out decision-making principles for establishing work causation.

2. The Act

Section 136(1):

> (1) Compensation is payable under this Part [Part 4 − Compensation to Injured Workers and Their Dependants] in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment if,
>
> (a) as applicable,
>
> (i) the worker has an occupational disease that disables the worker from earning full wages at the work at which the worker was employed, or
>
> (ii) the death of the worker is caused by an occupational disease, and
>
> (b) the occupational disease is due to the nature of any employment in which the worker was employed, whether under one or more employments.

Section 137:

> (1) This section applies to a worker who is disabled as referred to in section 136(1)(a)(i) as a result of an occupational disease described in column 1 of Schedule 1 of this Act.
>
> (2) If, on or immediately before the date of the disablement, the worker was employed in a process or industry described in column 2 of Schedule 1 opposite the occupational disease that has resulted in the disablement, the occupational disease must be presumed to have been due to the nature of the worker's employment unless the contrary is proved.

Section 139:

(1) In this section:

"heart disease" includes disease of the pericardium or coronary arteries;

"heart injury" includes heart attack, cardiac arrest or arrhythmia.

(2) Subject to subsection (4), if a worker

(a) is disabled as a result of a heart disease, and

(b) was employed as a firefighter on or immediately before the date of disablement from the heart disease,

the heart disease must be presumed to be due to the nature of the worker's employment as a firefighter unless the contrary is proved.

(3) Subject to subsection (4), if a worker

(a) is disabled as a result of a heart injury, and

(b) was employed as a firefighter on or immediately before the date of disablement from the heart injury, the heart injury must be presumed to have arisen out of and in the course of the worker's employment as a firefighter unless the contrary is proved.

(4) The presumptions in subsections (2) and (3) apply only to a worker who

(a) has been regularly exposed, throughout the worker's employment as a firefighter, to the hazards of a fire scene, and

(b) is first disabled as a result of the heart disease or heart injury, as applicable, on or after May 29, 2014.

Section 140:

(1) Subject to subsections (2) and (3), if a worker who is or has been a firefighter contracts

(a) primary site lung cancer, or

(b) a disease prescribed by regulation under subsection (4),

the disease must be presumed to be due to the nature of the worker's employment as a firefighter unless the contrary is proved.

(2) The presumptions in subsection (1) do not apply to a worker unless the worker

(a) has worked as a firefighter for the minimum cumulative period prescribed by regulation under subsection (4) for the applicable disease,

(b) throughout the period referred to in paragraph (a), has been regularly exposed to the hazards of a fire scene, and

(c) is first disabled from the disease on or after the following date, as applicable:

(i) in the case of primary site lung cancer, May 27, 2008;

(ii) in the case of a disease that was prescribed on or before March 18, 2009 for the purposes of subsection (1)(b), April 11, 2005;

(iii) in the case of a disease prescribed after March 18, 2009 for the purposes of subsection (1)(b), the date on which the regulation took or takes effect, as applicable.

(3) In addition to the conditions established by subsection (2), the presumption for primary site lung cancer does not apply to a worker unless the worker

(a) has, in the worker's lifetime, smoked a combined total of fewer than 365 cigarettes, cigars and pipes, or

(b) has been a non-smoker of tobacco products immediately before the date on which the worker is first disabled from that disease for the minimum period prescribed by regulation under subsection (4).

(4) The Lieutenant Governor in Council may make regulations for the purposes of this section, including regulations that

(a) establish minimum cumulative periods for the purposes of subsection (2), which may be defined differently, and be different, for different categories of firefighters, and

(b) establish minimum periods for the purposes of subsection (3), which may be different for different types or amounts of previous tobacco product usage.

Section 143:

(1) This section applies to a deceased worker who, on the date of the worker's death,

(a) was under 70 years of age, and

(b) had an occupational disease of a type that impairs the capacity of function of the lungs.

(2) If the death was caused by an ailment or impairment of the lungs or heart of non-traumatic origin, it must be conclusively presumed that the death resulted from the occupational disease.

POLICY

The fundamental requirement for an occupational disease to be compensable under section 136(1) of the *Act* is that the occupational disease that the worker has is "due to the nature of any employment in which the worker was employed, whether under one or more employments".

There are two approaches to establishing work causation: presumptions under the *Act*, and non-Scheduled recognition.

A. SCHEDULE 1 PRESUMPTION

The primary significance of Schedule 1 is with its use as a means of establishing work causation.

The fundamental purpose of Schedule 1 is to avoid the repeated effort of producing and analyzing medical and other evidence of work-relatedness for a disease where research has caused the Board to conclude that such disease is specific to a particular process, agent or condition of employment (see Section C. of Item C4-25.10). Once included in Schedule 1, it is presumed in individual cases that fit the disease and process/industry description that the cause was work-related. A claim covered by Schedule 1 can be accepted even though no specific evidence of work relationship is produced. A review of the available medical and scientific evidence would establish a likely relationship between the disease and the employment. The listing in the Schedule avoids the effort of producing the evidence in every case. Where the research does not clearly relate the disease to particular employments, the disease is not listed in Schedule 1 and the issue of work-relatedness must be determined on a case-by-case basis (see Section C., below).

If at the time a worker becomes disabled by a disease listed in Schedule 1, or if immediately before such date, such worker was employed in the process or industry described in column 2 of the Schedule opposite to such occupational disease, the worker is entitled to a presumption that the occupational disease was caused by the worker's employment, "unless the contrary is proved". This presumption applies whether the occupational disease manifests itself while the worker is at work, at home, while away on holidays, or elsewhere. The words "immediately before" used in section 137(2) are intended to deal with those situations where someone has been employed in the process or industry described in the Schedule, and has left that employment a very short time prior to the onset of the disease.

If a worker becomes disabled by a disease listed in Schedule 1 but at the relevant time had not been employed in the process or industry described in the Schedule, the claim may still be an acceptable one, however no presumption in favour of work-relatedness would apply. In this event establishing work causation follows the approach covered in Section C., below.

Inclusion of the words "unless the contrary is proved" in section 137(2) means that the presumption is rebuttable. Even though the decision-maker need not consider whether working in the described process or industry is likely to have played a causative role in giving rise to the occupational disease, the decision-maker must still consider whether there is evidence which rebuts or refutes the presumption of work-relatedness.

The standard of proof to be applied in determining whether the presumption has been rebutted is proof on a balance of probabilities. Balance of probabilities means "more likely than not." If the evidence is more heavily weighted in favour of a conclusion that it was something other than the employment that caused the disease, then the contrary will be considered to have been proved and the presumption is rebutted. The presumption is not rebutted because there is a lack of evidence to support work causation. The gathering and weighing of evidence generally is covered in Items C12-97.00 through C12-97.50.

Difficulties may arise in determining whether the worker was employed in the process or industry described in column 2 of the Schedule. This often arises because of the use of such words as "excessive" or "prolonged". While the Board would like to define more precisely the amount and duration of exposure required instead of using these words, it is usually not possible. The exact amounts will often vary according to the particular circumstances of the work place and the worker, or may not be quantified with sufficient precision by the available research. However, while such words are of uncertain meaning, there is valid reason for inserting them. Individual judgment must be exercised in each case to determine their meaning, having regard to the medical and other evidence available as to what is a reasonable amount or duration of exposure.

B. ADDITIONAL PRESUMPTIONS IN THE WORKERS COMPENSATION ACT

The *Act* provides the following additional presumptions:

- Mental disorder presumption (see section 135 of the *Act*);
- Firefighters' occupational disease or personal injury presumption respecting heart injury and heart disease (see section 139 of the *Act)*;
- Firefighters' occupational disease presumption respecting lung cancer and other diseases (see section 140 of the *Act*);
- Non-traumatic lung or heart ailment or impairment presumption for workers who die when under 70 years of age with a lung-impairing occupational disease (see section 143 of the *Act*); and
- Communicable disease presumption (see section 144 of the *Act)*.

C. WHERE NO PRESUMPTIONS APPLY

The designation or recognition of an occupational disease by inclusion in Schedule 1, under section 138(2) by regulation of general application, or under section 138(4), where a particular process, trade or occupation is specified, does not preclude the disease's designation or recognition as an occupational disease in a specific case by order under section 138(3) of the *Act*, if the disease occurs prior to its designation or recognition by one of the alternate methods.

In some cases a worker may have:

- an occupational disease not listed in Schedule 1;
- an occupational disease listed in Schedule 1 but not be employed in the process or industry described opposite to it in the Schedule;
- an occupational disease listed in the regulation of general application, where the process or industry of work-relatedness is not identified; and/or
- a disease not previously designated or recognized by the Board as an occupational disease.

In all these situations, the decision on whether the disease is due to the nature of any employment in which the worker was employed, is determined on the merits and justice of the claim without the benefit of any presumption. The same is true if for any other reason the requirements of section 137 are not met.

The occupational disease is due to the nature of the worker's employment if the employment was of causative significance in producing the disease. Causative significance means more than a trivial or insignificant aspect.

The Board will conduct a detailed investigation of the worker's circumstances including information about the worker, the worker's diagnosed condition, and the worker's workplace activities. The Board is seeking to gather evidence to establish whether the worker's employment was of causative significance in producing the disease. The gathering and weighing of evidence generally is covered in Items C12-97.00 through C12-97.50. The Board gathers the relevant evidence and determines whether it is sufficiently complete and reliable to arrive at a sound conclusion with confidence. If not, the Board considers what other evidence might be obtained, and must take the initiative in seeking further evidence. Although the nature of the evidence to be obtained and the weight to be attached to it is entirely in the hands of the Board, to be sufficiently complete the Board should obtain evidence from both the worker and the employer, particularly if the Board is concerned about the accuracy of some of the evidence obtained.

Since workers' compensation in British Columbia operates on an inquiry basis rather than on an adversarial basis, there is no onus on the worker to prove the worker's case. All that is needed is for the worker to describe the worker's personal experience of the disease and the reasons why the worker suspects the disease has an occupational basis. It is then the responsibility of the Board to research the available scientific literature and carry out any other investigations into the origin of the worker's condition which may be necessary. There is nothing to prevent the worker, the worker's representative, or physician from conducting their own research and investigations, and indeed, this may be helpful to the Board. However, the worker will not be prejudiced by a failure or inability to find the evidence to support the claim. Information resulting from research and investigations conducted by the employer may also be helpful to the Board.

As stated in Item C12-97.10, a worker is also assisted in establishing a relationship between the disease and the work by section 339 of the *Act* that provides:

(1) The Board may consider all questions of fact and law arising in a case, but the Board is not bound by legal precedent.

(2) The Board must make its decision based on the merits and justice of the case, but in doing this the Board must apply the policies of the board of directors that are applicable in that case.

(3) If the Board is making a decision respecting the compensation or rehabilitation of a worker and the evidence supporting different findings on an issue is evenly weighted in that case, the Board must resolve that issue in a manner that favours the worker.

For decisions respecting the compensation or rehabilitation of a worker, the standard of proof under section 339(3) of the *Act* is "at least as likely as not." If the evidence supporting different findings on an issue is evenly weighted, the issue will be resolved in favour of the worker.

This standard of proof is different than medical or scientific standards of certainty. Therefore, the presence or absence of expert evidence supporting or opposing a causal link is relevant and will generally be given weight by the Board, but it is not determinative of causation; causation can be inferred from other evidence. In every case, the Board decides whether the evidence supports a finding of causation based on a weighing of the evidence.

If the evidence before the Board does not support a finding that the disease is due to the nature of the worker's employment, the Board's only possible decision is to deny the claim.

i. Natural Degeneration of the Body

It often happens that disability results from the natural aging process. At times the pace of the process and each aspect of it can be influenced by environmental circumstances and activity. Work, leisure activities, genetic factors, air purity, diet, medical care, personal hygiene, personal relations and psychological make-up are all factors that may influence the pace of many kinds of natural degeneration. Where the degeneration is of a kind that affects the population at large, it is difficult for the Board to attempt a measurement of the significance of each occupation on each kind of degeneration. It is also difficult to determine whether a particular occupation had any significant effect in advancing the pace of degeneration compared with other occupations, or compared with a life of leisure. Where a degenerative process or condition is of a kind that affects the population at large, it will not be designated or recognized by the Board as an occupational disease unless employment causation can be established.

If a worker has a kind of bodily deterioration that affects the population at large, it is not compensable simply because of a possibility that work may be one of the range of variables influencing the pace of that degeneration. For the disability to be compensable, the worker's employment must have been of causative significance. The evidence must establish it is "at least as likely as not" that the work activity brought about an occupational disease that would not otherwise have occurred, or that the work activity advanced the development of a disability that would otherwise not have occurred until later.

For example, osteoarthritis in the spine, rheumatoid arthritis, and degenerative disc disease have not been designated or recognized as occupational diseases under sections 138(1), (2), or (4) of the *Act* (Sections C., D. and F. of Item C4-25.10).

ii. Aggravation of a Disease

Where a worker has a pre-existing disease which is aggravated by work activities to the point where the disease disables the worker, and where such pre-existing disease would not have been disabling in the absence of that work activity, the Board will accept that it was the work activity that disables the worker and pay compensation. Evidence that the pre-existing disease has been accelerated, activated, or advanced more quickly than would have occurred in the absence of the work activity, may be confirmation that the aggravation resulted from the employment activity.

Where the pre-existing disease was compensable, the Board must decide if the aggravation should be treated as a new claim or as a reopening of an earlier claim.

An aggravation of a pre-existing disease which is attributed to a specific event or trauma, or to a series of specific events or traumas, will be treated as a personal injury and will be adjudicated in accordance with the policies set out in Chapter 3. For example, a worker who injures the back while performing a series of awkward lifts at work may aggravate an underlying degenerative disc disease, or a worker with subacromial bursitis may strain the shoulder while completing a particular lift.

An aggravation of a pre-existing disease which is not attributed to a specific event or trauma, or to a series of specific events or traumas, will be treated as a disease. For example, a worker with a prior history of carpal tunnel syndrome may aggravate such condition to the point of requiring surgery as a result of several weeks of exposure to vibrating equipment.

Where a compensable aggravation of a pre-existing disease occurs, consideration will be given to relief of costs under section 240(1)(d) of the *Act*. If a permanent disability results, consideration is also given to proportionate entitlement under section 146 of the *Act.* (See Item C17-114.40.)

EFFECTIVE DATE:	July 14, 2025
AUTHORITY:	Section 136 of the *Act.*
CROSS REFERENCES:	Item C4-25.10, *Has a Designated or Recognized Occupational Disease*; Item C12-97.00, *Evidence – General*; Item C12-97.10, *Evidence Evenly Weighted*; Item C12-97.20, *Presumptions*; Item C12-97.30, *Medical Evidence*; Item C12-97.40, *Evidence – Other Matters*; Item C12-97.50, *Surveillance*; Item C17-114.40, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*; Appendix 2, Schedule 1, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:

December 1, 2025 – Housekeeping change to update internal cross-references, consequential to reformatting and renumbering Chapter 12, *Claims Procedures* and Chapter 17*, Charging of Claim Costs*.
July 14, 2025 – Amendments to ensure consistency for pre-existing diseases as between personal injury and occupational disease claims.
April 6, 2020 – This policy resulted from the consolidation of former policy items #26.20, #26.21, #26.22, #26.23, #26.50, and #26.55, consequential to the implementation of the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. The examples in Section C.i. of naturally degenerative conditions of the body that have not been designated or recognized as occupational diseases are derived from *Workers Compensation Reporter* series Decisions No. 99 (1975), 2 W.C.R. 15 and No. 205 (1976), 3 W.C.R. 16.
February 1, 2020 – Former policy item #26.20 was amended to remove "and onus of proof." Former policy items #26.21, #26.23, and #26.50 were amended to provide guidance regarding the legal issues of standard of proof, evidence, and causation.
March 1, 2019 – Former policy items #26.21 and #26.23 were consequentially amended to reflect the addition of then policy item #97.70, *Surveillance*, to the *Manual*.
July 23, 2018 – Former policy item #26.22 was consequentially amended in accordance with changes to then section 5.1 of the *Act*, resulting from the *Workers Compensation Amendment Act, 2018*, Bill 9 of 2018.
May 1, 2017 – Former policy item #26.20 was updated to identify the two approaches to establishing work causation. Former policy item #26.21 was consequentially amended to reflect renumbering of former policy item #26.23. Former policy item #26.22 was amended to add a reference to the firefighters' presumption and communicable disease presumption provided in the *Act*. Former policy item #26.23 was renumbered from #26.22.
June 1, 2009 – Former policy item #26.23 (then policy item #26.22) deleted references to Board officers.
June 1, 2004 – Former policy item #26.21 had statements adopting a broad interpretation of the phrase "immediately before" deleted.
March 3, 2003 – Former policy item #26.23 (then policy item #26.22) added new wording of then section 99 of the *Act*.
July 16, 2002 – Housekeeping changes were made to former policy item #26.21.

APPLICATION:

Applies to all decisions, including appellate decisions, made on or after July 14, 2025.

RE: Disabled from Earning Full Wages at Work **ITEM: C4-25.30**

BACKGROUND

1. Explanatory Notes

This policy sets out the legislative requirement that the worker be disabled from earning full wages at work.

2. The Act

Section 136, in part:

> (1) Compensation is payable under this Part [Part 4 − Compensation to Injured Workers and Their Dependants] in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment, if
>
> (a) as applicable,
>
> (i) the worker has an occupational disease that disables the worker from earning full wages at the work at which the worker was employed, or
>
> ...

Section 143:

> (1) This section applies to a deceased worker who, on the date of the worker's death,
>
> (a) was under 70 years of age, and
>
> (b) had an occupational disease of a type that impairs the capacity of function of the lungs.
>
> (2) If the death was caused by an ailment or impairment of the lungs or heart of non-traumatic origin, it must be conclusively presumed that the death resulted from the occupational disease.

POLICY

No compensation other than health care benefits are provided to a worker who has an occupational disease (with the exception of silicosis, asbestosis, or pneumoconiosis, and claims for hearing loss to which section 145 of the *Act* apply) unless that occupational disease "disables the worker from earning full wages at the work at which the worker was employed". No compensation is payable in respect of a deceased worker unless the worker's death was caused by an occupational disease (or is presumed to have resulted from an occupational disease under section 143 of the *Act*).

Health care benefits may be provided for a worker who has an occupational disease even though the worker is not disabled from earning full wages at the work at which the worker was employed.

There is no definition of "disability" in the *Act.* The phrase "that disables the worker from earning full wages at the work at which the worker was employed" refers to the work at which the worker was regularly employed on the date the worker was disabled by the occupational disease. This means that for compensation beyond health care benefits to be paid there must be some loss of earnings from such regular employment as a result of the disabling effects of the disease, and not just an impairment of function. For example, disablement for the purposes of section 136(1) may result from:

- an absence from work in order to recover from the disabling effects of the disease;
- an inability to work full hours at such regular employment due to the disabling effects of the disease;
- an absence from work due to a decision of the employer to exclude the worker in order to prevent the infection of others by the disease;
- the need to change jobs due to the disabling effects of the employment.

A worker who must take time off from the worker's usual employment to attend medical appointments is not considered disabled by virtue of that fact alone. However, the Board may pay a subsistence allowance for income loss to such a worker (see Item C10-83.10).

A change of employment or lay-off from work for the purpose of precluding the onset of a disability does not amount to a disability for this purpose.

For time limits with respect to occupational disease claims see Section B. of Item C4-26.00.

EFFECTIVE DATE:	April 6, 2020
AUTHORITY:	Section 136 of the *Act.*
CROSS REFERENCES:	Item C4-26.00, *"Date of Injury" For Occupational Disease*; Item C10-83.10, *Subsistence Allowances*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 – This policy replaced former policy item #26.30, consequential to the implementation of the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
APPLICATION:	This Item applies to all decisions, including appellate decisions, made on or after April 6, 2020.

RE: "Date of Injury" For Occupational Disease	ITEM: C4-26.00

BACKGROUND

1. Explanatory Notes

This policy sets out the decision-making principles for determining the “date of injury” for occupational disease.

2. The Act

Section 136, in part:

(1) Compensation is payable under this Part [Part 4 − Compensation to Injured Workers and Their Dependants] in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker’s employment, if

(a) as applicable,

(i) the worker has an occupational disease that disables the worker from earning full wages at the work at which the worker was employed, or

(ii) the death of the worker is caused by an occupational disease, and

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

(2) For the purposes of subsection (1), the date of disablement must be treated as the occurrence of the injury.

...

Section 151:

(1) An application for compensation must

(a) be made on the form directed by the Board or prescribed by regulation, and

(b) be signed by the worker or the worker's dependant making the application.

(2) If the Board is satisfied that compensation is payable, it may be paid without an application.

(3) Except as provided in this section and section 152, no compensation is payable unless an application for compensation is filed, or a determination under subsection (2) of this section is made, within one year after the date of the worker's injury, mental disorder, death or disablement from occupational disease.

(4) The Board may pay the compensation provided under this Part [Part 4 – Compensation to Workers and Their Dependants] if

(a) an application is not filed within the period referred to in subsection (3),

(b) the Board is satisfied that special circumstances existed that precluded filing within that period, and

(c) the application is filed within 3 years after the date referred to in subsection (3).

(5) The Board may pay the compensation provided under this Part [Part 4 – Compensation to Workers and Their Dependants] for the period beginning on the date the Board receives an application for compensation if

(a) an application is not filed within the period referred to in subsection (3),

(b) the Board is satisfied that special circumstances existed that precluded filing within that period, and

(c) the application is filed more than 3 years after the date referred to in subsection (3).

Section 152:

(1) The Board may pay the compensation provided under this Part [Part 4 – Compensation to Workers and Their Dependants] if

(a) the application for compensation arises from a worker's death or disablement due to an occupational disease,

(b) sufficient medical or scientific evidence was not available on the date referred to in section 151(3) 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 that sufficient medical or scientific evidence, as determined by the Board, became available to the Board.

(2) If, since July 1, 1974, the Board considered an application for compensation under the equivalent of this section or section 151 in respect of a worker's death or disablement from occupational disease, the Board may reconsider the application but must apply subsection (1) of this section in the reconsideration.

POLICY

A. GENERAL

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

The date of the worker's first seeking treatment by a physician or qualified practitioner for the occupational disease is used for administrative purposes. For example, this date will be used where there is no lost earnings. Where the worker's condition was not at that time diagnosed as an occupational disease, the relevant date is the date the occupational disease is first diagnosed.

B. TIME LIMITS AND DELAYS IN APPLYING FOR COMPENSATION

A person must apply for compensation for death or disablement due to an occupational disease within the time limits set out in sections 151 and 152 of the *Act*. That person can be the worker or the worker's dependant(s) if the worker has died. People who delay in applying for compensation may lose or limit their right to compensation because the Board can only consider an application on its merits if the requirements of section 151 are met. One of the purposes of these time limits is to ensure the Board is given early notice of the claim so that the relevant evidence can be obtained when it is more readily available.

A person applying for compensation for an occupational disease must generally do so within one year of the date of death or disablement (in most cases a disablement will precede any death). There are exceptions provided in sections 151(4) and 151(5), as noted below. If the worker is alive and if the occupational disease has never caused a disablement, then time has not yet started to elapse for the purposes of section 151.

Where a worker has experienced more than one period of disablement from the occupational disease for which the worker intends to claim, then each period of disablement will have to be individually considered to determine if the requirements of section 151 are met with respect to that period.

Under the terms of a predecessor to the current section 152, a claim must be denied if a person applies to the Board more than one year after the worker's most recent disablement or after the worker's death if:

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

C. APPLICANTS WHO FILE WITHIN THREE YEARS

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

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

Special circumstances are discussed in Item C12-93.11.

If special circumstances do not exist, the Board cannot consider the claim, unless it meets section 152(1), because the application will be out of time.

D. APPLICANTS WHO FILE BEYOND THREE YEARS

A person who applies more than three years after the date of death or disablement due to the occupational disease might still receive compensation under section 151(5). If special circumstances precluded applying within one year, the Board may still consider starting compensation payments from the date the Board received the application. However, the Board cannot consider compensation payments for periods before that date, unless the claim meets the requirements of section 152(1).

If special circumstances do not exist, the Board cannot consider an application more than three years after the date of death or disablement due to an occupational disease if it does not meet the requirements of section 152(1), because the application will be out of time.

E. NEWLY RECOGNIZED OCCUPATIONAL DISEASES

As noted in Section A. of Item C4-25.00, it is often more difficult to determine whether a person's employment caused a disease than to determine whether it caused a personal injury. Our knowledge about the role a particular kind of employment may have in causing various diseases changes over time. In recognition of this difficulty, section 152 applies only to claims for occupational disease.

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

1. At the time of the worker's death or disablement, the Board does not have sufficient medical or scientific evidence to recognize the disease as an occupational disease for this worker's kind of employment (even though the Board may have recognized it as an occupational disease for other kinds of employment).

2. The Board subsequently obtains sufficient medical or scientific evidence to enable it to recognize the disease as an occupational disease for this worker's kind of employment.

3. The application for compensation is filed within three years after the date the Board recognized the disease as an occupational disease for the worker's kind of employment.

The Board is not precluded from recognizing a disease by order dealing with a specific case, even if the disease occurs prior to the Board designating or recognizing it under one of sections 138(1), 138(2), or 138(4) (see Item C4-25.00, Section E.).

If, after July 1, 1974, and before August 26, 1994, the Board has considered an application for compensation in respect of a worker's death or disablement from occupational disease, and has determined that all or part of the claim cannot be paid because of the wording of former section 55 then in effect, the Board may now under section 152(2) reconsider the claim and pay compensation for those periods previously denied if it meets the requirements of section 152(1).

For example, in the 1970s sufficient medical or scientific evidence was not available for the Board to recognize an association between exposure to coal tar pitch volatiles in aluminum smelters and an excess risk of bladder cancer. It was not until the late 1980s that sufficient evidence became available for the Board to recognize such an association. (However, the Board had earlier recognized that there was an association

between bladder cancer and prolonged exposure to certain chemicals used primarily in the manufacture of rubber and dyes. In 1980 "primary cancer of the epithelial lining of the urinary bladder" was added to then Schedule B (now Schedule 1), with a corresponding presumption in favour of causation where the worker had prolonged exposure to any of three listed chemicals.)

On March 13, 1989, the Board issued a policy directive recognizing bladder cancer as an occupational disease for workers employed in aluminum smelting, dependent on the concentration and length of exposure to coal tar pitch volatiles.

Section 152(1) allows the Board to consider the payment of compensation for any worker disabled by bladder cancer who was exposed to sufficient doses of coal tar pitch volatiles while employed in the aluminum smelting industry if:

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

Section 152(2) allows the Board to reconsider any claims for bladder cancer that meet the requirements of section 152(1) and to pay compensation for any periods previously denied because of the wording of the earlier former section 55 in effect since July 1, 1974. The language of section 152 came into effect on August 26, 1994. If a claim for bladder cancer is filed after March 13, 1992, then the requirements of sections 151(3), (4), or (5) must be met before compensation can be paid.

F. DISCRETION TO PAY COMPENSATION

As stated in Item C12-93.11, even though special circumstances may have precluded the filing of the application within one year, the Board has discretion under section 151 whether or not to pay compensation. In exercising that discretion, the Board considers whether the time elapsed since the death or disability due to the occupational disease has prejudiced its ability to investigate the merits of the claim, including determining whether the worker was disabled from earning full wages at the work at which the worker was employed.

The Board considers the availability of evidence, such as:

- medical records about the worker's state of health at relevant times (cause of death in the case of a deceased worker)

- employment records that may document exposures to contaminants or hazardous processes, or periods of disability that may have been due to the occupational disease

- evidence from co-workers or others who may know about the worker's employment activities.

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

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

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

EFFECTIVE DATE:	May 1, 2024
AUTHORITY:	Section 136 of the *Act.*
CROSS REFERENCES:	Item C4-25.00, *Occupational Disease*; Item C12-93.11, *Time Allowed for Submission of Application*; Appendix 2, Schedule 1, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – Housekeeping change to update internal cross-references, consequential to reformatting and renumbering Chapter 12, *Claims Procedures*. May 1, 2024 – Policy amended to clarify language related to time limits for applying for compensation for occupational disease. October 21, 2020 – Amended to reflect amendment to limitation period provision in the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020. April 6, 2020 – This policy resulted from the consolidation of former policy items #32.50, #32.55, #32.56, #32.57, #32.58, and #32.59, consequential to the implementation of the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Former policy item #32.50 deleted references to Board officer. October 1, 2007 – Former policy item #32.50 was revised to delete reference to assigning a claim member. March 3, 2003 – Former policy item #32.58 was amended to reflect the new wording of then section 55(3.3). Former policy item #32.59 was revised to reference the Review Division.
APPLICATION:	Applies to all decisions, including appellate decisions, made on or after May 1, 2024.

RE:	Activity-Related Soft Tissue Disorders ("ASTDs") of the Limbs	ITEM:	C4-27.00

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the adjudication of ASTDs of the limbs.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

Section 136, in part:

> (1) Compensation is payable under this Part [Part 4 − Compensation to Injured Workers and Their Dependants] in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment, if
>
> (a) as applicable,
>
> (i) the worker has an occupational disease that disables the worker from earning full wages at the work at which the worker was employed, or
>
> (ii) the death of the worker is caused by an occupational disease, and
>
> (b) the occupational disease is due to the nature of any employment in which the worker was employed, whether under one or more employments.
>
> (2) For the purposes of subsection (1), the date of disablement must be treated as the occurrence of the injury.

POLICY

A. DEFINITION OF ASTD

The terms “cumulative trauma disorder”, “repetitive strain injury”, “repetitive motion disorder”, “occupational overuse syndrome”, “occupational cervicobrachial disorder”, “hand/arm vibration syndrome”, “work-related musculoskeletal disorder”, and others, are broad collective terms used to describe a diverse group of soft tissue disorders which may or may not be caused or aggravated by employment activities. Each of these collective terms can be misleading. They may imply the presence of “repetition” or “trauma” or “motion” or “work-relatedness” where in fact the cause of the disorder may be due in whole or in part to other factors that are not work-related.

The common elements of the disorders included in these collective terms are:

- they are related to physical activity; and
- they affect muscles, tendons, and other soft tissues.

The Board uses the term ASTDs to describe this group of disorders of the limbs which may or may not be caused or aggravated by employment activities.

B. PERSONAL INJURY OR OCCUPATIONAL DISEASE

The following policies deal with the compensability of ASTDs affecting the limbs, and specifically ASTDs that are recognized as occupational diseases in Schedule 1 (see Section C. of Item C4-25.10) or by regulation (see Section D. of Item C4-25.10).

Where an ASTD is attributed to a sudden trauma or an infection due to a penetrating wound, it will be treated as an injury and adjudicated in accordance with the policies in Chapter 3 (see Item C3-12.00). A claim made by a worker diagnosed with an ASTD where no specific trauma or penetrating wound has occurred, will be treated as a disease and adjudicated in accordance with the policies in Chapter 4 of this *Manual*.

The Board will adjudicate a claim made by a worker under both section 134 and section 136 of the *Act,* and in accordance with the policies found in Chapter 3 and Chapter 4, where either:

- there is an unclear ASTD diagnosis and the evidence indicates the condition may be either an injury or a disease; or

- there is a clear ASTD diagnosis but the evidence indicates the condition may be either an injury or a disease.

C. DEFINITIONS OF NERVE ENTRAPMENT AND TENDINOPATHY

The majority of the ASTDs discussed in this section can be classified as nerve entrapments or tendinopathies. A nerve entrapment occurs when nerve function is affected by mechanical anatomical factors that compress the nerve, such as, tight muscles or tendons, lesions, bony irregularities or swelling.

Tendinopathy is a generic descriptor of the clinical conditions in and around tendons, characterized by a combination of pain, swelling and impaired functioning. Tendinopathy encompasses tendinitis, which implies an inflammatory tendon condition, and tendinosis, which implies a degenerative tendon condition. The term tendinitis can be misleading because it is often used to describe all painful tendon conditions, even when there is a lack of inflammatory change.

EFFECTIVE DATE:	July 14, 2025
AUTHORITY:	Sections 134, 136, and 319 of the *Act.*
CROSS REFERENCES:	Item C3-12.00, *Personal Injury*; Item C4-25.10, Has a Designated or Recognized Occupational Disease, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	July 14, 2025 – Updating language. April 6, 2020 – This policy replaced sections 1 to 3 of former policy item #27.00, consequential to the implementation of the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Former policy item #27.00 was amended to provide direction when adjudicating ASTD claims where the condition may be either an injury or a disease, and to further emphasize the importance for the Board to base its decisions on the merits and justice of the case. March 1, 2015 – Former policy item #27.00 provided guidance on adjudicating ASTDs generally. It incorporated language from former policy items #27.00, *Activity-Related Soft Tissue Disorders of the Limbs*, #27.11, *Bursitis*, #27.12, *Tendinitis and Tenosynovitis*, #27.20, *Tendinitis/Tenosynovitis and Bursitis Claims Where No Presumption Applies*, and #27.40, *Risk Factors*. The policy provided guidance on adjudicating ASTDs as either personal injuries or occupational diseases, included the definitions for “nerve entrapment” and “tendinopathy” and included guidance on factors relevant to establishing work causation of ASTDs and risk factors generally.
APPLICATION:	Applies to all decisions, including appellate decisions, made on or after July 14, 2025.

RE: Establishing Work Causation for ASTDs of the Limbs ITEM: C4-27.10

BACKGROUND

1. Explanatory Notes

This policy provides guidance for establishing work causation for ASTDs of the limbs.

2. The Act

Section 136, in part:

> (1) Compensation is payable under this Part [Part 4 − Compensation to Injured Workers and Their Dependants] in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment, if
>
> (a) as applicable,
>
> (i) the worker has an occupational disease that disables the worker from earning full wages at the work at which the worker was employed, or
>
> (ii) the death of the worker is caused by an occupational disease, and
>
> ...

Section 137(2):

> If, on or immediately before the date of the disablement, the worker was employed in a process or industry described in column 2 of Schedule 1 opposite the occupational disease that has resulted in the disablement, the occupational disease must be presumed to have been due to the nature of the worker's employment unless the contrary is proved.

Section 138, in part:

> (2) The Board may, by regulation of general application, designate or recognize a disease as an occupational disease.

(3) The Board may, by order, designate or recognize a disease as an occupational disease in a specific case.

...

POLICY

A. ESTABLISHING WORK CAUSATION

The method by which an ASTD is designated or recognized by the Board as an occupational disease affects how the Board determines work causation.

When the strength of association between a process or industry and a specific ASTD is strong, the Board may include it in Schedule 1, with the benefit of the rebuttable presumption provided for in section 137 of the *Act*.

Where the Board designates or recognizes a disease as an occupational disease by regulation of general application as provided for in section 138(2) of the *Act*, or by order in a specific case as provided for in section 138(3) of the *Act*, there is no rebuttable presumption of work causation. In these cases, the Board determines whether a worker's employment was of causative significance in causing or aggravating the worker's ASTD based on the circumstances of the individual case, with consideration of risk factors set out in policy, and the current medical/scientific evidence (see Item C4-25.20).

Causative significance means more than a trivial or insignificant aspect. The employment (the employment-related exposure to risk factors) need not be the sole or even the predominant cause; the employment only needs to have been of causative significance.

In weighing the evidence, the Board must take into account all of the relevant facts and circumstances relating to the case before it, including the worker's individual characteristics. The Board makes its decisions based on the merits and justice of the case, but in doing this the Board applies the applicable Board policies.

Evidence that the worker's ASTD has been accelerated, activated or advanced more quickly than would have occurred in the absence of the employment, may be confirmation that their employment was of causative significance in aggravating the ASTD.

In determining whether the worker's employment was of causative significance in causing or aggravating the worker's ASTD, the Board considers:

- the mechanics of the employment activity in question (e.g. is the condition bilateral, while the employment activity to a greater degree required movement of the limb on one side?);
- whether any changes took place in the worker's employment or non-employment activities prior to or at the time of onset of the ASTD;
- whether there is evidence of ASTD onset in those who perform the same type of employment or non-employment activities as the worker;
- the potential combined effect of activities in more than one employment; and
- whether the worker has pre-existing injuries, diseases or other conditions that may be associated with the onset of the ASTD at issue, and the cause of such conditions.

When making the above determination, the Board recognizes that:

- ASTDs may be caused by exposure to employment-related risk factors, but they may also be caused by exposure to non-employment-related risk factors that occur as part of everyday life (e.g. while playing recreational sports);
- some cases of an ASTD may be idiopathic (occurring without known cause) where a causal agent cannot be identified;
- some ASTDs may develop over hours while others develop over years;
- two or more ASTDs may exist simultaneously; a second ASTD may occur as the result of adjusting to, or compensating for, the first;
- some people are more susceptible to the development of ASTDs than others. This is not a bar to compensation. The worker's employment will have been of causative significance if the employment-related exposure to risk factors was more than a trivial or insignificant aspect in causing or aggravating the ASTD; and
- ASTDs are often caused by exposure to a combination of risk factors, rather than just one risk factor. However, for some ASTDs and under certain conditions, a single risk factor may be of causative significance if the exposure to that risk factor is of a particularly high degree of intensity, magnitude or duration.

B. ANALYZING RISK FACTORS

Determining whether an ASTD is due to the nature of a worker's employment requires an analysis of risk factors relevant to the causation of ASTDs for the purposes of section 138(2) and (3). The Board considers all relevant risk factors in a particular case. The presence or absence of some risk factors may suggest work causation, while the presence or absence of others may suggest non work-related causation. Both employment-related exposure to risk factors and non-employment-related exposure to risk factors may contribute to the ASTD. Work causation is proved if it is "at least as likely as not" the worker's employment was of causative significance in causing or aggravating the worker's ASTD.

Risk factors may act directly in causing an ASTD or they may act indirectly by creating the conditions that may lead to an ASTD. Risk factors are not equal nor can they be consistently ranked in order of importance. Their relative importance will vary with the circumstances of each claim. Individual judgment is exercised in each case to determine the weight to be given to each risk factor having regard to the available evidence.

When assessing whether a worker's employment was of causative significance in the development of an ASTD, the Board generally considers how the worker interacts with the work environment and the following employment-related risk factors:

- cold temperature: cold may have direct damaging effects on the tissue through vascular constriction and other mechanisms;
- dose: the level of intensity of a risk factor over a specific duration;
- duration: the length of time a worker is exposed to a particular risk factor;
- force: the physical effort a worker must exert to perform a particular movement or activity;
- frequency: the number of repetitions of a complete sequence of tasks or movements of a process occurring per unit of time during a work cycle;
- grip type: the posture of the hand required for a worker to grasp an object to perform a particular movement or activity. Different types of grips require the application of different force levels;
- hand-arm vibration: the vibration that is transmitted from vibrating surfaces of objects such as hand tools, through the hands and arms;
- local contact stresses: the results from physical pressure between body tissues and objects in the work environment such as tools, machinery, and products;

- magnitude: the degree of exposure to a noted risk factor;
- posture: refers to postures that are awkward. Postures are awkward when joints are held at or near the end of range of motion or muscle tension is required to hold the posture without movement;
- repetition: the cyclical use of the same body tissues either as a repeated motion or as a repeated muscular effort without movement. Consideration is given to the:
    - work cycle;
    - work period; and
    - work-recovery (rest) cycle;
- static load: sustain a given level of muscle force/exertion for a duration of time, against gravity or against some other external force;
- task variability: the degree to which the task remains unchanged thus causing loading of the same tissues in the same way;
- unaccustomed activity: tissues not being acclimatized to the activities performed;
- work cycle: an exertion period and a recovery (or smaller exertion) period necessary to complete one sequence of a task, before the sequence is repeated; and
- work-recovery (rest) cycle: the availability and distribution of breaks in a particular activity to allow the tissue to return to a resting state for recovery.

This is not an exhaustive list, and relevant factors not listed in policy may also be considered.

When assessing whether one of the above noted employment-related risk factors caused or contributed to the development of a worker's ASTD, the Board considers:

- the location of the anatomical structure affected (e.g. the elbow);
- the risk factors involved in the worker's employment activities;
- the muscle groups, tendons and joints involved in performing the worker's employment activities; and
- whether there is a biologically plausible connection between the employment activities and the development of the ASTD, taking into consideration the worker's individual characteristics.

EFFECTIVE DATE:	July 14, 2025
AUTHORITY:	Sections 134, 136, and 137 of the *Act.*
CROSS REFERENCES:	Item C4-25.10, *Has a Designated or Recognized Occupational Disease* (Section C. *Recognition by Inclusion in Schedule 1*, and Section D. *Recognition by Regulation of General Application*); Item C4-25.20, *Establishing Work Causation*; Appendix 2, Schedule 1, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	July 14, 2025 – Amendments to clarify the work causation analysis for ASTDs of the limbs. April 6, 2020 – This policy replaced sections 4 and 5 of former policy item #27.00, consequential to the implementation of the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Amendments include providing direction when adjudicating ASTD claims where the condition may be either an injury or a disease, and further emphasizing the importance of considering all of the relevant ASTD risk factors in a particular case, and for the Board to base its decisions on the merits and justice of the case. March 1, 2015 − Former policy item #27.00 provided guidance on adjudicating ASTDs generally. It incorporated language from former policy items #27.00, *Activity-Related Soft Tissue Disorders of the Limbs,* #27.11, *Bursitis*, #27.12, *Tendinitis and Tenosynovitis*, #27.20, *Tendinitis/Tenosynovitis and Bursitis Claims Where No Presumption Applies,* and #27.40, *Risk Factors*, of the *Rehabilitation Services & Claims Manual*, Volume II. This policy provided guidance on adjudicating ASTDs as either personal injuries or occupational diseases. The definitions of the terms nerve entrapment and tendinopathy were included. Guidance on factors relevant to establishing work causation of ASTDs and risk factors generally were included.
APPLICATION:	Applies to all decisions, including appellate decisions, made on or after July 14, 2025.

RE: ASTDs Recognized by Inclusion in Schedule 1 **ITEM: C4-27.20**

BACKGROUND

1. Explanatory Notes

This policy provides guidance for adjudicating ASTDs recognized in Schedule 1.

2. The Act

Section 1, in part:

> **"occupational disease"** means a disease ... that is
>
> (a) a disease identified in Schedule 1 *[Presumption of Occupational Disease Related to Specific Process or Industry]* of this Act,
>
> ...

Section 136, in part:

> (1) Compensation is payable under this Part in [Part 4 − Compensation to Injured Workers and Their Dependants] relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment, if
>
> (a) as applicable,
>
> (i) the worker has an occupational disease that disables the worker from earning full wages at the work at which the worker was employed, or
>
> ...

Section 137:

> (1) This section applies to a worker who is disabled as referred to in section 136(1)(a)(i) as a result of an occupational disease described in column 1 of Schedule 1 of this Act.
>
> (2) If, on or immediately before the date of the disablement, the worker was employed in a process or industry described in column 2 of Schedule 1 opposite the occupational disease that has resulted in the disablement,

the occupational disease must be presumed to have been due to the nature of the worker's employment unless the contrary is proved.

Schedule 1:

See Appendix 2.

POLICY

The following ASTDs are recognized as occupational diseases by inclusion in Schedule 1: hand-wrist tendinopathy (Section A. of this policy), shoulder tendinopathy and shoulder bursitis (Section B. of this policy), knee bursitis (Section C. of this policy), and hand-arm vibration syndrome (Section D. of this policy).

The general application of the Schedule 1 presumption for establishing work causation is discussed in Section A. of Item C4-25.20.

If the worker was not employed in the process or industry in Schedule 1 for the specified ASTD (i.e., the descriptions in column 2 opposite to the ASTD are not met), the presumption does not apply. The Board then determines compensability in accordance with Item C4-27.10 on a case-by-case basis (see Section E., below).

A. HAND-WRIST TENDINOPATHY

Schedule 1 lists "hand-wrist tendinopathy" as an occupational disease (Schedule 1 item 14(1)). Schedule 1 provides a rebuttable presumption that hand-wrist tendinopathy is due to the nature of employment where a worker was employed in a process or industry:

> Where there is use of the affected tendon or tendons to perform a task or series of tasks that involve any 2 of the following and where such activity represents a significant component of the employment:
>
> (a) frequently repeated motions or muscle contractions that place strain on the affected tendon or tendons;
>
> (b) significant flexion, extension, ulnar deviation or radial deviation of the affected hand or wrist;
>
> (c) forceful exertion of the muscles used in handling or moving tools or other objects with the affected hand or wrist.

Tendinopathy is a generic descriptor of the clinical conditions in and around tendons, characterized by a combination of pain, swelling and impaired functioning.

Hand-wrist tendinopathy is characterized by a combination of pain, swelling and impaired functioning of the tendons around the hand-wrist.

The Board applies the following guiding principles when interpreting the descriptions used in Schedule 1 in connection with hand-wrist tendinopathy.

i. Frequently Repeated

In item 14(1) of Schedule 1, the words “frequently repeated motions or muscle contractions” mean a worker who is performing the same work task(s) again and again without interruption or rest between.

Generally, tasks that place strain on the affected tendon or tendons, and that are considered to involve “frequently repeated motions or muscle contractions” are repeated:

- at least once every 30 seconds; or
- with at least 50 percent of the work cycle spent performing the same motions or muscle contractions, and less than 50 percent of the work cycle time for the affected muscle/tendon groups to return to a relaxed or resting state.

For tasks that involve shorter work cycle frequencies or greater periods of rest and recovery time than referred to above, the Board may not consider a worker who has hand-wrist tendinopathy to be employed in the process or industry described in column 2 of Schedule 1. In these cases, there is no presumption of work causation, but the Board assesses whether a worker was performing “frequently repeated motions or muscle contractions” in the context of each individual case, and applies Section E. of this policy.

ii. Significant Flexion, Extension, Ulnar Deviation or Radial Deviation

In item 14(1) of Schedule 1, the words “significant flexion, extension, ulnar deviation or radial deviation of the affected hand or wrist” generally mean:

- moving (or holding) the hand or wrist in greater than 25 degrees of flexion from anatomical neutral (0 degrees);
- moving (or holding) the hand or wrist in greater than 45 degrees of extension from anatomical neutral (0 degrees);
- moving (or holding) the hand or wrist in greater than 10 degrees of ulnar deviation; or

- moving (or holding) the hand or wrist in greater than 10 degrees of radial deviation.

iii. Forceful Exertion

In item 14(1) of Schedule 1, the words “forceful exertion of the muscles used in handling or moving tools or other objects with the affected hand or wrist” mean that the muscles and tendons that are used are loaded to a significant proportion of the maximum mechanical limit of those tissues. This limit varies depending on factors such as the size, strength, and fitness level of the individual performing the work.

In determining whether the worker has been engaged in “forceful exertion” of the muscles utilized, the Board considers the following, including but not limited to:

- the weight of the tool or work object;
- the manner in which the tool or work object is moved (e.g., pushed, pulled, carried, lifted, lowered, gripped, pinched, etc.);
- the distance the tool or work object is moved;
- the speed at which the tool or work object is moved (extra force may be needed to start or stop moving objects);
- the amount of friction that exists between the tool or work object and the worker’s hand (slippery tools may require greater force to grip) or between the tool or work object and other surfaces (greater force may be required to overcome that friction);
- whether tools or work objects are handled using a pinch grip or a power grip (pinch grips exert more force on the tendons of the thumb and fingers);
- whether sustained force must be applied (after an initial force is applied); and
- whether the tool or work object is vibrating (greater force may be required to control a vibrating object).

Other evidence may be relevant to determining whether there was “forceful exertion” in the context of each individual case.

iv. Significant Component of the Employment

In item 14(1) of Schedule 1, the words “where such activity represents a significant component of the employment” mean that the worker has been exposed to the processes described in paragraphs (a), (b), and (c) of item 14(1) for sufficiently long that

it is biologically plausible that the hand-wrist tendinopathy resulted from the employment activities.

Employment activities that involve minimal or trivial use of the hand-wrist as described in item 14(1) do not amount to "a significant component of the employment".

For claims that do not meet the descriptions contained in item 14(1) of Schedule 1, there is no presumption of work causation, but the Board determines on the evidence whether the hand-wrist tendinopathy was due to the nature of the employment under section 136(1) of the *Act* (Section E. of this policy).

B. SHOULDER BURSITIS AND SHOULDER TENDINOPATHY

Schedule 1 lists "shoulder bursitis" (Schedule 1 item 13(2)) and "shoulder tendinopathy" (Schedule 1 item 14(2)) as occupational diseases. Schedule 1 provides a rebuttable presumption that shoulder tendinopathy and shoulder bursitis are due to the nature of employment where a worker was employed in a process or industry:

> Where there is frequently repeated or sustained abduction or flexion of the shoulder joint greater than 60º and where such activity represents a significant component of the employment.

Tendinopathy is a generic descriptor of the clinical conditions in and around tendons, characterized by a combination of pain, swelling and impaired functioning.

Bursitis is inflammation of a bursa (a sac-like cavity found at a site of potential friction between tendons and muscles and a bony prominence lying beneath them). By virtue of its anatomical proximity to less flexible structures, a bursa can become inflamed if it is subjected to excessive friction, rubbing or pressure. Bursitis may also be caused by other conditions including autoimmune diseases, general inflammatory diseases (such as rheumatoid arthritis) and bacterial infections typically following a puncture wound.

Shoulder bursitis and shoulder tendinopathy are characterized by a combination of pain, swelling, and impaired functioning around the tendons of the shoulder.

The Board applies the following guiding principles when interpreting the descriptions used in Schedule 1 in connection with shoulder bursitis (Schedule 1 item 13(2)) and shoulder tendinopathy (Schedule 1 item 14(2)).

i. Frequently Repeated Abduction or Flexion of the Shoulder Joint

In determining whether a particular work task involves "frequently repeated or sustained abduction or flexion of the shoulder joint greater than 60º", the Board considers the following, including but not limited to:

- the frequency of the work cycle for the tasks being performed (how often there is abduction or flexion of the shoulder joint greater than 60º);
- the amount of time during a work cycle that the affected muscle/tendon groups of the shoulder are working compared to the amount of time such tissues have to return to a relaxed or resting state;
- the amount of time between work cycles that the affected muscle/tendon groups of the shoulder have to return to a relaxed or resting state;
- whether other activities are performed between work cycles that require motions or muscle contractions that affect the ability of the affected muscle/tendon groups of the shoulder to return to a relaxed or resting state, and if so whether such activities are repetitive in nature.

Generally, tasks that are considered to involve "frequently repeated or sustained abduction or flexion of the shoulder joint greater than 60º" are repeated:

- at least once every 30 seconds; or
- with at least 50 percent of the work cycle spent in abduction or flexion and where the muscle/tendon groups of that shoulder have less than 50 percent of the work cycle time to return to a relaxed or resting state.

For tasks that involve less frequent repetition or greater periods of rest and recovery time than referred to above, the Board may not consider a worker who has shoulder bursitis or shoulder tendinopathy to be employed in the process or industry described in column 2 of Schedule 1. In these cases, there is no presumption of work causation, but the Board assesses whether the worker was performing "frequently repeated or sustained abduction or flexion of the shoulder joint greater than 60º" in the context of each individual case, and applies Section E. of this policy.

ii. Sustained Abduction or Flexion of the Shoulder Joint

In items 13(2) and 14(2) of Schedule 1, the words "sustained abduction or flexion of the shoulder joint" mean that the shoulder joint is held in a static position of abduction or flexion greater than 60º. Generally, the greatest pressure is placed on the shoulder bursa when there is between 60º and 120º of abduction or flexion (0º being when the arm is straight down by the side of the torso). The longer the shoulder joint is held in such a static position during the work cycle, and the less time the affected muscle/tendon groups of the shoulder have to return to a relaxed or resting state, the more one is able to conclude that the employment involves "sustained abduction or flexion of the shoulder joint".

Conversely, the less time the shoulder joint is held in such a static position during the work cycle, and the more time that the affected muscle/tendon groups of the shoulder

have to return to a relaxed or resting state, the less one is able to conclude that the employment involves "sustained abduction or flexion of the shoulder joint".

iii. Significant Component of the Employment

In items 13(2) and 14(2) of Schedule 1, the words "where such activity represents a significant component of the employment" mean that the worker has been performing work activities involving the described use of the shoulder joint for sufficiently long that it is biologically plausible that the inflammation or degeneration affecting the shoulder has resulted from the employment activities.

Employment activities that involve minimal or trivial use of the shoulder joint do not amount to "a significant component of the employment".

For claims that do not meet the descriptions contained in items 13(2) or 14(2) of Schedule 1, there is no presumption of work causation, but the Board determines on the evidence whether the shoulder bursitis or shoulder tendinopathy was due to the nature of the employment under section 136(1) of the *Act* (see Section E. of this policy).

C. KNEE BURSITIS

Schedule 1 lists "knee bursitis (inflammation of the prepatellar, suprapatellar, or superficial infrapatellar bursa)" as an occupational disease (Schedule 1 item 13(1)). Schedule 1 provides a rebuttable presumption that knee bursitis is due to the nature of employment where a worker was employed in a process or industry:

> Where
>
> (a) there is repeated jarring impact against the involved bursa, or
>
> (b) there are significant periods of kneeling on the involved bursa.

Bursitis is inflammation of a bursa (a sac-like cavity found at a site of potential friction between tendons and muscles and a bony prominence lying beneath them). By virtue of its anatomical proximity to less flexible structures, a bursa can become inflamed if it is subjected to excessive friction, rubbing or pressure. Bursitis may also be caused by other conditions including autoimmune diseases, general inflammatory diseases (such as rheumatoid arthritis) and bacterial infections typically following a puncture wound.

In item 13(1) of Schedule 1, the words "significant periods of kneeling" mean kneeling for a period of time that is sufficiently long that it is biologically plausible that bursitis resulted from the employment activities.

Employment activities that involve minimal or trivial periods of kneeling do not amount to a "significant period of kneeling".

For claims that do not meet the descriptions contained in item 13(1) of Schedule 1, there is no presumption of work causation, but the Board determines on the evidence whether the knee bursitis was due to the nature of the employment under section 136(1) of the *Act* (Section E. of this policy).

D. HAND-ARM VIBRATION SYNDROME ("HAVS")

Schedule 1 lists "hand-arm vibration syndrome" as an occupational disease (Schedule 1 item 17). Schedule 1 provides a rebuttable presumption that HAVS is due to the nature of employment where a worker was employed in a process or industry:

> Where there has been at least 1000 hours of exposure to tools or equipment that causes the transfer of significant vibration to the hand or arm of the worker.

HAVS is a condition also known as vibration-induced Raynaud's phenomenon or vibration-induced white finger.

Operators of vibratory tools or equipment may develop physiologic changes induced by that vibration. These tools and equipment include, but are not limited to, chainsaws, pneumatic drills, impact wrenches, chipping hammers, grinders, jackhammers, and polishers. Initial symptoms of these physiologic changes may include persistent numbness and tingling, swelling and/or blanching of the fingers.

The Board applies the following guiding principles when interpreting the descriptions used in Schedule 1 in connection with HAVS.

i. Dose

Dose is the most important risk factor in the development of HAVS. It is a function of both the level or intensity of the vibration and the duration of that vibration. It is generally considered that frequencies in the range of 5 to 1500 cycles per second can be hazardous. Intensity is usually measured by the level of acceleration of the vibrating tool (the time rate of change of the speed of the vibrating object measured in metres per second per second, or m/sec^2). The greater the dose of vibration (the greater the acceleration of the vibrating tool and/or the greater the cumulative hours of exposure to the vibration) the lower is the latency period measured from the time of first exposure to the vibration and the onset of symptoms of HAVS.

In order for the presumption to apply in the case of HAVS, there must have been at least 1000 hours of exposure. For claims that do not meet the descriptions contained in item 17 of Schedule 1, there is no presumption of work causation. It should be noted, however, that the condition could occur with exposures less than 1000 hours if the intensity of the exposure is significant. The Board determines on the evidence whether the HAVS was due to the nature of the employment under section 136(1) of the *Act* in the context of each individual case, and applies Section E. of this policy, below. Such cases are considered on their own merits.

ii. Significant Vibration to the Hand-Arm

In item 17 of Schedule 1, the words “significant vibration” is a recognition that the intensity of vibration experienced by the worker must be significant for the presumption in favour of work causation to apply. The Board assesses whether a worker was exposed to “significant vibration” in the context of each individual case.

Continuous exposure to vibration may increase the risk of developing HAVS when compared to exposure to vibration which is interrupted by rest periods (e.g. 10 minutes of rest during each hour of exposure).

The greater the grip force used to grasp the vibrating tool or equipment, the more efficient is the transfer of vibration energy to the hand or arm of the worker and the greater the risk that physiologic changes will occur. For some tools the greater the intensity of the vibration, the greater will be the grip force required to control the tool.

Anti-vibration gloves may absorb some of the higher frequencies (above 500 cycles per second) and allow workers to maintain hand temperatures and to prevent calluses. Conventional glove designs do little to absorb frequencies below 500 cycles per second. Some of these gloves may actually amplify lower frequencies.

iii. Other Considerations

Workers with pre-existing conditions such as connective tissue diseases or vascular diseases may be more susceptible to vibration-induced physiologic changes that may result in HAVS.

In order to conclude that a worker suffers from HAVS, the Board must first determine that the worker does not suffer from primary Raynaud’s disease (which is a recognized clinical entity that has no known cause) or from other non-vibration induced causes of secondary Raynaud’s phenomenon. These include, but are not limited to, collagen vascular disease, peripheral vascular disease, or peripheral neuropathies such as carpal tunnel syndrome. The presence or absence of these conditions should be commented upon by the physician who has assessed the worker.

Most compensable injuries and occupational diseases involve an initial period of temporary disability during which temporary total or temporary partial disability wage-loss benefits are paid. The physical impairment of the worker will usually improve in time until it disappears entirely or results in a permanent disability. However, in the case of some occupational diseases, there is no initial period of temporary disability; the disability is permanent right from the time it first becomes manifest as a disability and no wage-loss benefits are payable. HAVS is one of these diseases. Permanent disability benefits are payable in respect of the disabilities caused by these diseases only once a specified minimum level of impairment is reached. Wage-loss benefits are payable in those rare cases where a period of temporary disability results from the disease.

For claims that do not meet the descriptions contained in item 17 of Schedule 1, there is no presumption of work causation, but the Board determines on the evidence whether the HAVS was due to the nature of the employment under section 136(1) of the *Act* (see Section E. of this policy).

E. ASTDS LISTED IN SCHEDULE 1 WHERE NO PRESUMPTION APPLIES

If a worker has an ASTD listed in Schedule 1, but the worker was not employed in the process or industry described opposite to the disease in column 2 of Schedule 1, there is no presumption of work causation. In these cases, the Board determines on the evidence whether the occupational disease was due to the nature of the employment under section 136(1) of the *Act*, and in accordance with policy in Item C4-27.10.

Even if the requirements of column 2 of Schedule 1 are not met, Schedule 1 may still provide some guidance on the type of risk factors that may be considered in establishing work causation of the occupational disease in question. However, the requirements of column 2 of Schedule 1 are not the only matters to be considered. It is only where the presumption applies that it may be unnecessary to consider such other matters because work causation will already have been established.

EFFECTIVE DATE: July 14, 2025

AUTHORITY: Sections 1, 136(1), 137, and Schedule 1 of the *Act.*

CROSS REFERENCES:
Item C4-25.10, *Has a Designated or Recognized Occupational Disease* (Section C. Recognition by Inclusion in Schedule 1);
Item C4-25.20, *Establishing Work Causation*;
Item C4-27.00, *Activity-Related Soft Tissue Disorders ("ASTDs") of the Limbs*;
Appendix 2, Schedule 1, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:
July 14, 2025 – Amendments to clarify the work causation analysis for ASTDs of the limbs, and minor amendments made regarding the meaning of hand or wrist extension.
April 6, 2020 – This policy resulted from the consolidation of former policy items #27.10, #27.11, #27.12, #27.13, #27.14, and #27.20, consequential to the implementation of the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
February 1, 2020 – Former policy item #27.20 was amended to provide guidance regarding the legal issue of standard of causation, and to reflect title change to then policy item #26.23.
May 1, 2017 – Former policy item #27.20 was consequentially amended to reflect renumbering of then policy item #26.23 (formerly #26.22).
March 1, 2015 – Former policy item #27.10 was amended for clarity and to reflect the new numbering of the ASTD policies and terminology. Former policy item #27.11 was amended for clarity by including reference to specific text of the then Schedule B presumption, along with definitions of tendinopathy and hand-wrist tendinopathy; the definition of hand-wrist tendinopathy was updated; and the descriptions of flexion and

extension were clarified. Former policy item #27.12 was amended by including reference to specific text of the then Schedule B presumption, along with updated definitions of shoulder tendinopathy and shoulder bursitis; terms from former policy item #27.00 were included; policy direction on bursitis, and tendinitis and tenosynovitis were combined because the two conditions share the same risk factors. Former policy item #27.13 was amended by including reference to specific text of the then Schedule B presumption, including modifying the wording of the then Schedule B presumption to refer to the "involved bursa" instead of the "affected knee", along with an updated definition of bursitis. Former policy item #27.14 had minor changes for clarity. Former policy item #27.20 had a title change; included all ASTDs listed in then Schedule B where there is no presumption; cross referenced to then policy item #26.23 was added because it provided general guidance on this topic; content was updated so that it applied to any ASTD where no presumption applies.

June 1, 2009 – Deleted references to Board officers.

APPLICATION: Applies to all decisions, including appellate decisions, made on or after July 14, 2025.

RE: ASTDs Recognized by Regulation **ITEM: C4-27.30**

BACKGROUND

1. Explanatory Notes

This policy provides guidance for adjudicating ASTDs recognized by regulation.

2. The Act

Section 136(1):

> Compensation is payable under this Part [Part 4 − Compensation to Injured Workers and Their Dependants] in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment, if
>
> (a) as applicable,
>
> (i) the worker has an occupational disease that disables the worker from earning full wages at the work at which the worker was employed, or
>
> (ii) the death of the worker is caused by an occupational disease, and
>
> (b) the occupational disease is due to the nature of any employment in which the worker was employed, whether under one or more employments.

Section 138(2):

> The Board may, by regulation of general application, designate or recognize a disease as an occupational disease.

POLICY

The following ASTDs, which may be caused or aggravated by employment activities, have been designated or recognized as occupational diseases by regulation of general application, under section 138(2) of the *Act*:

- Bursitis (other than the forms of bursitis mentioned in item 13 of Schedule 1 of the *Act*);
- Carpal Tunnel Syndrome;
- Cubital Tunnel Syndrome;
- Disablement by vibrations;
- Hypothenar Hammer Syndrome;
- Plantar Fasciitis;
- Radial Tunnel Syndrome;
- Tendinopathy (other than the forms of tendinopathy mentioned in item 14 of Schedule 1 of the *Act*), including:
    - Epicondylopathy (lateral and medial), and
    - Stenosing Tenosynovitis (Trigger Finger); and
- Thoracic Outlet Syndrome.

For occupational diseases recognized by regulation under section 138(2), there is no presumption in favour of work causation. These occupational diseases are compensable only if the evidence establishes in the particular case that the occupational disease is due to the nature of any employment in which the worker was employed (see policy in Section C. of Item C4-25.20, and policy in Item C4-27.00).

Medical/scientific evidence indicates that some employment-related risk factors are associated with the causation of some of the ASTDs recognized as occupational diseases by regulation under section 138(2). As discussed in the sections below and in Item C4-27.40, the Board recognizes that such employment-related risk factors are associated with causation of particular ASTDs. However, the Board also considers other employment-related and non-employment-related risk factors associated with causation of ASTDs in every case where the Schedule 1 presumption does not apply (see policy in Item C4-27.00).

A. EPICONDYLOPATHY

Epicondylopathy is a tendinopathy that is recognized as an occupational disease by regulation under section 138(2) of the *Act*.

Epicondylopathy can be divided into lateral epicondylopathy, which is known as tennis elbow, and medial epicondylopathy, which is known as golfer's elbow. The lateral epicondyle of the elbow is the bony origin for common wrist extensors and supinator

tendons. The medial epicondyle is the bony origin for common wrist flexors and pronator tendons.

Lateral epicondylopathy is characterized by pain at the lateral elbow with contraction of the muscles that extend the wrist, as in gripping and resisting wrist extension.

Medial epicondylopathy is characterized by pain at the medial elbow with contraction of the muscles that extend and flex the wrist, such as gripping and resisted wrist flexion.

Medical/scientific evidence on epicondylopathy does not as a whole confirm a strong association with employment activities and its mechanisms of development are obscure. Some individual studies do indicate an excess incidence of epicondylopathy in employments with tasks strenuous to the muscle-tendon structures of the arm. One often referred to theory suggests that microtears at the attachment of the muscle to the bone may be due to repetitive activity with high force sufficient to exceed the strength of the collagen fibres of the tendon attachment. This in turn may lead to the formation of fibrosis and granulation tissue.

As the medical/scientific evidence does not clearly relate epicondylopathy to any particular process or industry, the Board assesses work causation in the context of each individual case based on consideration of all relevant risk factors.

The Board recognizes that where the worker was performing frequent, repetitive, forceful and unaccustomed, employment-related movements (including forceful grip) of the wrist that are reasonably capable of stressing the inflamed tissues of the arm affected by epicondylopathy, and in the absence of evidence suggesting a non work-related cause for the worker's epicondylopathy condition, a strong likelihood of work causation will exist. These factors are not preconditions to the acceptance of a claim for epicondylopathy nor are they the only factors that may be relevant. For example, lateral epicondylopathy has been shown to occur in tennis players (some studies showing a strong causative association) who are well accustomed to the motions and forces involved. The issue to be determined in any individual claim is whether the evidence leads to a conclusion that the epicondylopathy is due to the nature of the worker's employment.

B. CARPAL TUNNEL SYNDROME

Carpal tunnel syndrome is recognized as an occupational disease by regulation under section 138(2) of the *Act*.

Carpal tunnel syndrome is a condition caused by intermittent or continuous compression or entrapment of the median nerve as it passes through the carpal tunnel from the wrist to the hand. Increased pressure on the median nerve in the carpal tunnel can result in progressive sensory and motor disturbances in parts of the hand innervated by this nerve, leading to pain and loss of function. There are many causes of such a median nerve compression, both employment-related and non-employment-

related. Carpal tunnel syndrome occurs in the general population and often without any obvious cause.

Some theories suggest that repetitive stretching or compression of the median nerve in the carpal tunnel results in inflammation of the tissue. This may lead to tissue scarring and a reduction of the size of the carpal canal resulting in compression of the nerve. Ischemia (restriction of blood flow) may also play a role in causing carpal tunnel syndrome. A gradual thickening of the transverse carpal ligament, which may occur spontaneously with aging, has also been suggested as a possible mechanism.

A comparison of medical/scientific evidence on carpal tunnel syndrome indicates that work activities utilizing the hand/wrist that involve high repetition associated with high force, prolonged flexed postures of the wrist, high repetition associated with cold temperatures, or the use of hand-held vibrating tools are more likely to be associated with increased risk for carpal tunnel syndrome.

Non-employment-related risk factors include diseases or conditions that may contribute to reducing the size of the carpal canal including diabetes mellitus, rheumatoid arthritis, thyroid disorders, gout, ganglion formation, and other non-rheumatic inflammatory diseases. Pregnancy and use of oral contraceptives are associated with increased risk for carpal tunnel syndrome. Other factors for which there is some evidence, at times conflicting, include hysterectomy, excision of both ovaries, age at menopause, obesity, and estrogen imbalances. The size of the carpal canal may be reduced by a Colles' fracture (which may or may not have occurred in the course of employment activities). The existence of such non-employment-related factors does not reduce the importance of the nature of the employment activities.

The Board recognizes that where the worker was performing frequent, repetitive and forceful, employment-related movements of the hand/wrist, including gripping, (particularly if unaccustomed) that are reasonably capable of stressing the tissues of the hand/arm affected by carpal tunnel syndrome, and in the absence of evidence suggesting a non-work-related cause for the worker's condition, a strong likelihood of work causation will exist. These factors are not preconditions to the acceptance of a claim for carpal tunnel syndrome nor are they the only factors that may be relevant.

The Board also considers whether the condition is bilateral (involving both wrists) and whether both wrists became symptomatic at the same or different times, in light of the degree to which each hand/wrist is utilized in carrying out the employment activities. As both hands may not perform identical activities and are therefore subject to different risk factors, a work-related carpal tunnel syndrome may be more likely to be unilateral. Carpal tunnel syndrome due to systemic illness is more likely to be bilateral. The Board also considers whether the symptoms of carpal tunnel syndrome improve with rest (stopping work) or whether they continue to progress or worsen. The latter may suggest a non-work-related cause.

As the medical/scientific evidence does not clearly relate carpal tunnel syndrome to any particular process or industry, the Board assesses work causation in the context of each individual case based on consideration of all relevant risk factors.

C. OTHER PERIPHERAL NERVE ENTRAPMENTS AND STENOSING TENOSYNOVITIS

Cubital tunnel syndrome, radial tunnel syndrome, thoracic outlet syndrome, and the tendinopathy stenosing tenosynovitis (trigger finger) are each recognized as an occupational disease by regulation under section 138(2) of the *Act*.

Cubital tunnel syndrome is a nerve entrapment in the upper limb and is caused by pressure on or stretching of the ulnar nerve near the elbow at the cubital tunnel.

Radial tunnel syndrome is characterized by symptoms of forearm pain without weakness when the radial nerve is pinched. The nerve enters the forearm at the lateral side of the elbow, where it passes next to and under the muscle of the lateral forearm. The space through which the nerve traverses may be narrowed by thick and tensed muscles, fibrous bands or other soft tissue swelling, and the nerve may be pinched as it travels past the narrowed area.

Thoracic outlet syndrome is the compression of the nerves and/or vessels, in the thoracic outlet region, by the anatomical structures in the area (bone, muscle, and connective tissues). The thoracic outlet is the area above the first rib and behind the clavicle.

Stenosing tenosynovitis (or trigger finger) is characterized by a fibrous thickening of the tendon sheath that results in a snapping movement of a finger due to swelling and restricted gliding of the tendon. It is often called “trigger finger”. This condition most commonly involves the flexor tendons of the hand.

Each of these ASTDs may be caused or aggravated by employment or non-employment-related activities, particularly in an individual who by virtue of their specific anatomical makeup is susceptible to these disorders.

As the medical/scientific evidence does not clearly relate any of these conditions to any particular process or industry, the Board assesses work causation in the context of each individual case based on consideration of all relevant risk factors.

D. HYPOTHENAR HAMMER SYNDROME

Hypothenar hammer syndrome is recognized as an occupational disease by regulation under section 138(2) of the *Act*.

This condition is due to repeated blunt trauma to the ulnar border of the affected hand. It will often occur in workers who use their bare hand as a hammer in order to strike or pound hard objects. The area of the hand where contact is made is usually the

hypothenar eminence. Repeated blows to this ulnar portion of the hand can result in thrombosis or aneurysm formation in the branches of the ulnar artery, which in turn can produce a painful lump in the hypothenar area and/or numbness in the fourth or fifth fingers.

There are a number of non-employment-related activities which may involve repeated blunt trauma to the ulnar border or other parts of the hand (e.g., participation in some martial arts or self defense activities, certain sports, such as handball and baseball, or playing certain percussion instruments). In the investigation of a claim for hypothenar hammer syndrome the Board will determine how and to what extent the worker uses the affected hand in striking or pounding objects in both employment-related and non-employment-related settings.

As the medical/scientific evidence does not clearly relate hypothenar hammer syndrome to any particular process or industry, the Board assesses work causation of hypothenar hammer syndrome in the context of each individual case based on consideration of all relevant risk factors.

E. PLANTAR FASCIITIS

"Plantar Fasciitis" is recognized as an occupational disease by regulation under section 138(2) of the *Act*.

Plantar fasciitis is the name given to non-specific inflammation of the plantar fascia (a sheet of fibrous tissue on the plantar surface of the foot). The inflammation most commonly occurs in the heel (origin of the plantar fascia, at the calcaneus) and arch areas of the foot.

The Board generally accepts that plantar fasciitis can be related to significant unusual strain placed on the plantar fascia. Similarly, the Board generally considers that workers are at an increased risk for developing plantar fasciitis when they are exposed to direct trauma to the bottom of the foot through an accident, or when there is a significant unaccustomed physical strain or impact to the bottom of the foot. The Board defines the force, impact, or unusual strain to the bottom of the foot through an analysis of work activities.

As the medical/scientific evidence does not clearly relate plantar fasciitis to any particular process or industry, the Board assesses work causation in the context of each individual case based on consideration of all relevant risk factors.

EFFECTIVE DATE: April 6, 2020
AUTHORITY: Sections 136 and 138(2) of the *Act.*
CROSS REFERENCES: Item C4-25.10, *Has a Designated or Recognized Occupational Disease* (Section D. Recognition by Regulation of General Application);

Item C4-25.20, *Establishing Work Causation* (Section C. Where No Presumptions Apply);
Item C4-27.00, *Activity-Related Soft Tissue Disorders ("ASTDs") of the Limbs*;
Item C4-27.10, *Analyzing Risk Factors for ASTDs*;
Item C4-27.40, *ASTDs Recognized by Order in a Specific Case (Non-Specific Symptoms or Unspecified Non-Traumatic Diagnoses of the Limbs)*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:

April 6, 2020 – This policy resulted from the consolidation of former policy items #27.30, #27.31, #27.32, #27.33, #27.35, and #27.36, consequential to the implementation of the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
February 1, 2020 – Housekeeping change to former policy item #27.30 to reflect the title change of then policy item #26.23.
May 1, 2017 – Former policy item #27.30 was consequentially amended to reflect the renumbering of former policy item #26.23 (previously #26.22).
December 1, 2015 – Former policy item #27.30 was consequentially amended as a result of the creation of then policy item #27.36. Former policy item #27.36 was newly created by BOD Resolution No. 2015/10/22-02.
March 1, 2015 – Former policy item #27.30 was amended to reorder conditions alphabetically and add bursitis and plantar fasciitis to the list; conditions were listed as a subset under tendinopathy; the term "epicondylopathy" was used in place of "epicondylitis"; "stenosing tenovaginitis (trigger finger)" replaced with "stenosing tenosynovitis" based on current medical science; introduction added regarding how the risk factors set out in then policy item #27.31 through #27.35 should be weighed in determining whether a claim is accepted. Former policy item #27.31 adopted the term "epicondylopathy" in place of "epicondylitis"; definition updated based on current medical science; minor policy changes made for clarity and consistency with other ASTD policies. Former policy item #27.32 updated the definition of carpal tunnel syndrome, based on current medical science; minor changes were made for clarity and consistency with other ASTD policies. Former policy item #27.33 updated the definitions of cubital tunnel syndrome, radial tunnel syndrome, thoracic outlet syndrome, and stenosing tenosynovitis; minor policy changes made for clarity and consistency with other ASTD policies. Former policy item #27.35 was moved to be listed after former policy item #27.30; minor changes were made for clarity and consistency with the other ASTD policies.

APPLICATION:

This Item applies to all decisions, including appellate decisions, made on or after April 6, 2020.

RE:	Non-Specific Symptoms or Unspecified Non-Traumatic Diagnoses of the Limbs	ITEM:	C4-27.40

BACKGROUND

1. Explanatory Notes

This policy provides guidance for adjudicating ASTDs recognized by order in a specific case.

2. The Act

Section 1, in part:

> **"occupational disease"** means a disease ... that is
>
> (c) a disease designated or recognized by order under section 138(3) *[Board order in specific case]*,
>
> ...

Section 138(3):

> The Board may, by order, designate or recognize a disease as an occupational disease in a specific case.

POLICY

A worker may have a gradual onset of symptoms that appear to be musculoskeletal or nerve-related and that are not categorized as any of the clinical entities described in the policy of Item C4-27.20 or C4-27.30.

The Board considers a claim of this nature on its own merits under section 138(3) of the *Act,* even though a clinical entity familiar to the Board has not been diagnosed. The matters referred to in Section E. of Item C4-25.10 would apply to such a claim. The Board should, however, make whatever inquiries it considers appropriate in the context of the claim to determine whether the worker in fact has one or more of the disorders referred to in the policy of Item C4-27.20 or C4-27.30. The Board does this particularly when the symptoms cannot be categorized into a disease entity or syndrome, or when the diagnosis provided is a general one such as "repetitive strain injury", "cumulative trauma disorder", "overuse syndrome", "occupational cerviobrachial syndrome", or the like.

EFFECTIVE DATE:	April 6, 2020
AUTHORITY:	Sections 136 and 138(3) of the *Act.*
CROSS REFERENCES:	Item C4-25.10, *Has a Designated or Recognized Occupational Disease* (Section E. Recognition by Order Dealing with a Specific Case); Item C4-25.20, *Establishing Work Causation* (Section C. Where No Presumptions Apply); Item C4-27.00, *Activity-Related Soft Tissue Disorders ("ASTDs") of the Limbs*; Item C4-27.10, *Analyzing Risk Factors for ASTDs*; Item C4-27.20, *ASTDs Recognized by Inclusion in Schedule 1*; Item C4-27.30, *ASTDs Recognized by Regulation*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 – This policy replaced former policy item #27.34, consequential to the implementation of the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. March 1, 2015 − Minor changes for clarity, including change to policy title. June 1, 2009 – Deleted references to Board officers.
APPLICATION:	This Item applies to all decisions, including appellate decisions, made on or after April 6, 2020.

RE: Contagious Diseases **ITEM: C4-28.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance for adjudicating contagious diseases recognized as an occupational disease.

2. The Act

Section 136, in part:

> (1) Compensation is payable under this Part [Part 4 − Compensation to Injured Workers and Their Dependants] in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment, if
>
> (a) as applicable,
>
> (i) the worker has an occupational disease that disables the worker from earning full wages at the work at which the worker was employed, or
>
> (ii) the death of the worker is caused by an occupational disease, and
>
> (b) the occupational disease is due to the nature of any employment in which the worker was employed, whether under one or more employments.
>
> (2) For the purposes of subsection (1), the date of disablement must be treated as the occurrence of the injury.
>
> ...

Section 137(2):

> If, on or immediately before the date of the disablement, the worker was employed in a process or industry described in column 2 of Schedule 1 opposite the occupational disease that has resulted in the disablement, the occupational disease must be presumed to have been due to the nature of the worker's employment unless the contrary is proved.

Section 138(1):

> The Board may, by regulation, do the following:
>
> (a) add to or delete from Schedule 1 of this Act a disease that, in the opinion of the Board, is an occupational disease;
>
> (b) add to or delete from that Schedule a process or an industry;
>
> (c) set terms, conditions and limitations for the purposes of paragraphs (a) and (b) of this subsection.

POLICY

A. CONTAGIOUS DISEASES RECOGNIZED BY INCLUSION IN SCHEDULE 1

The following contagious diseases are recognized as occupational diseases by inclusion in Schedule 1:

- Item 2: Infection caused by

  (1) Psittacosis virus
  (2) Salmonella organisms, Staphylococcus aureus, Hepatitis B virus
  (3) Brucella organisms, including Undulant fever
  (4) Tubercle bacillus.

- Item 20: Infection that is

  (1) caused by communicable viral pathogens, and
  (2) the subject of one or more of the following:
    (a) notice given under section 52(2) of the *Public Health Act*;
    (b) a state of emergency declared under section 9(1) of the *Emergency Program Act*;
    (c) a state of local emergency declared under section 12(1) of the *Emergency Program Act*;
    (d) an emergency declared under section 173 of the *Vancouver Charter*.

The general application of the Schedule 1 presumption for establishing work causation is discussed in Section A. of Item C4-25.20 such that the worker must be employed in the process or industry described in column 2 of the Schedule.

B. CONTAGIOUS DISEASES RECOGNIZED BY REGULATION

The following contagious diseases have been designated or recognized as occupational diseases by regulation of general application, under section 138(2) of the *Act*:

- Campylobacteriosis (diarrhea caused by Campylobacter)
- Chicken Pox
- Giardia Lamblia Infestation
- Head lice (Pediculosis Capitis)
- Hepatitis A
- Herpes Simplex
- Legionellosis
- Meningitis
- Mononucleosis
- Mumps
- Red Measles (Rubeola)
- Ringworm
- Rubella
- Scabies
- Shigellosis
- Staphylococci infections
- Streptococci infections
- Typhoid
- Whooping Cough
- Yersiniosis

For occupational diseases recognized by regulation under section 138(2), there is no presumption in favour of work causation, so a worker is not entitled to compensation simply because the worker contracted the disease while at work. For the disability to be compensable, there must be something in the nature of the employment which had causative significance. Thus, in these cases of contracting a contagious disease at work, it is a requirement for compensation that either:

1. The nature of the employment created for the worker a risk of contracting a kind of disease to which the public at large is not normally exposed; or

2. The nature of the employment created for the worker a risk of contracting the disease significantly greater than the ordinary exposure risk of the public at large. In this category, it would not be sufficient to show only that the worker meets more people than workers in other occupations, but it would be significant to show that in the particular employment the worker meets a much larger proportion of people with the particular disease than is found in the population at large.

It may help to illustrate these principles:

Example 1 — Suppose an outbreak of meningitis is affecting the community at large. The disease may be spreading at places of work, in the home, at schools, at churches, at social events, at sporting events, and every place where people meet. The Board would not, with regard to each worker who has the disease, seek evidence to decide whether that worker contracted the disease at work or elsewhere. The disease would be viewed as a public health problem, not a disease due to the nature of any particular employment, and compensation for the workers involved must be found under general systems relating to sickness benefits, not under workers' compensation.

Example 2 — Suppose there are three cases of meningitis reported in the community. Victim 1 is a tourist from abroad. Victim 2 is a nurse who was engaged in the treatment of Victim 1. Victim 3 is a nurse who was working closely with Victim 2. Here the employment involved a risk of contracting a disease of a kind to which the public at large are not exposed, and the contracting of the disease by Victims 2 and 3 was due to the nature of their employment.

Example 3 — Suppose a courier develops mononucleosis and claims compensation on the ground that in the job the courier meets more people than workers in most occupations and therefore has a greater risk of exposure to contagious diseases. Such a claim would not be allowed. The disease is one that spreads in the population at large, and claims of this nature cannot be allowed or denied by estimating the extent to which each employment involves mixing with the public.

i. Scabies

The Board recognizes scabies as an occupational disease by regulation of general application under section 138(2) of the *Act*.

Claims for scabies will be accepted if the following three conditions are met:

1. The worker is employed in a hospital, nursing home, or other institution where there is a recognized hazard of contracting an infectious disease, or is directly involved in transporting patients or residents to or from such facilities.

2. There is satisfactory evidence the worker has had contact with an infected patient, resident or co-worker at the place of employment and the condition has occurred within a reasonable period of time following such contact (measured against the known incubation period for scabies). Evidence that there were persons in the place of employment known to have scabies is sufficient for this purpose if the worker would normally have direct contact with such persons in the performance of employment duties.

3. The diagnosis of scabies is confirmed by a staff occupational health nurse, or by a physician or other qualified practitioner, and is not simply speculative. Skin scrapings need not be taken in order to give a positive diagnosis of scabies.

If any of the three conditions have not been met, the evidence is unlikely to support a finding that the worker has scabies due to the nature of the worker's employment.

As noted in Section D. of Item C4-25.10, many contagious diseases recognized as occupational diseases by regulation of general application are not likely to be "…due to the nature of any employment in which the worker was employed…" except for hospital employees, or workers at other places of medical care.

C. CONTAGIOUS DISEASES RECOGNIZED BY ORDER IN A SPECIFIC CASE

A worker may contract a contagious disease at work that the Board has not recognized as an occupational disease by inclusion in Schedule 1 or by regulation. The worker is not entitled to compensation simply because the worker contracted the disease while at work. The Board applies the policy in Section E. of Item C4-25.10 to recognize or designate the contagious disease as an occupational disease. The Board applies the principles set out above in Section B. of this policy to determine if the disability is compensable.

It may help to illustrate these principles:

Example 1 — Suppose the disease is one of a low order of contagiousness, and one that does not normally spread through the public at large, but which can be contagious when there is exceptionally close contact, such as may come from two workers constantly holding materials together, or sharing the same room. If, in this situation, a worker catches the disease from a fellow worker, from the employer, or from a client of the employer, with whom the worker has been placed in exceptionally close proximity, it may well be concluded that the disease is due to the nature of the employment. For example, where two workers share sleeping quarters on board a ship, and one contracts tuberculosis (which is also recognized by regulation as an occupational disease) from the other, the worker who contracted tuberculosis from the shipmate may be compensated.

Example 2 — Suppose a maintenance mechanic from British Columbia is sent to repair machinery in use by a customer overseas. While there, the worker contracts a disease that is commonly found among the population at large in that country, but which is not a common disease in British Columbia. That would be compensable. The nature of the employment has exposed the worker to a disease of a kind to which the people of British Columbia are not normally exposed.

D. ESTABLISHING WORK CAUSATION

There is no requirement that a worker with a contagious disease should name a contact, but there should be some evidence of a contact. For example, if the worker was employed in a hospital, and there were three patients known to be in the worker's working area of the hospital who have the disease, an inference may be drawn from the circumstantial evidence that the worker contracted the disease there, even though the worker may not remember the names of the patients, or may not remember whether there was actual contact with them. The strength of this circumstantial evidence would obviously depend partly on the strength of evidence relating to alternative possibilities, such as whether the disease is extremely rare or one that is common in the community elsewhere. In other words, where there is no solid evidence of actual contact, the Board must still weigh the possibilities on the circumstantial evidence of possible contact and not simply reject the claim without weighing the possibilities.

EFFECTIVE DATE:	August 20, 2020
AUTHORITY:	Sections 136, 137, and 138 of the *Act.*
CROSS REFERENCES:	Item C4-25.10, *Has a Designated or Recognized Occupational Disease*; Item C4-25.20, *Establishing Work Causation*; Appendix 2, Schedule 1, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	August 20, 2020 – Consequential amendment resulting from amending Schedule 1 to include infections caused by communicable viral pathogens that are the subject of a BC-specific emergency declaration or notice. April 6, 2020 – This policy resulted from the consolidation of former policy items #28.00 and #28.10, consequential to the implementation of the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Former policy item #28.10 was amended to provide guidance on the legal issues of standard of proof, evidence, and causation.
APPLICATION:	This Item applies to all decisions made on or after August 20, 2020.

RE: Respiratory Diseases	ITEM: C4-29.00

BACKGROUND

1. Explanatory Notes

This policy provides guidance in adjudicating respiratory diseases, other than pneumoconiosis.

2. The Act

Section 136:

(1) Compensation is payable under this Part [Part 4 − Compensation to Injured Workers and Their Dependants] in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment, if

(a) as applicable,

(i) the worker has an occupational disease that disables the worker from earning full wages at the work at which the worker was employed, or

(ii) the death of the worker is caused by an occupational disease, and

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

(2) For the purposes of subsection (1), the date of disablement must be treated as the occurrence of the injury.

(3) A health care benefit may be provided for a worker who has an occupational disease referred to in subsection (1)(b) even though the worker is not disabled from earning full wages at the work at which the worker was employed.

Section 137:

(1) This section applies to a worker who is disabled as referred to in section 136(1)(a)(i) as a result of an occupational disease described in column 1 of Schedule 1 of this Act.

(2) If, on or immediately before the date of the disablement, the worker was employed in a process or industry described in column 2 of Schedule 1 opposite the occupational disease that has resulted in the disablement, the occupational disease must be presumed to have been due to the nature of the worker's employment unless the contrary is proved.

Section 138(2):

The Board may, by regulation of general application, designate or recognize a disease as an occupational disease.

Schedule 1:

See Appendix 2.

POLICY

A. ASTHMA

Item 7 of Schedule 1 lists "Asthma" as an occupational disease. The process or industry described in column 2 opposite to it is "Where there is exposure to any of the following:

(a) western red cedar dust;

(b) isocyanate vapours or gases;

(c) the dusts, fumes or vapours of other chemicals or organic material known to cause asthma."

i. Evidence of Exposure

There are many substances which are either known to cause asthma in a previously healthy individual, or to aggravate or activate an asthmatic reaction in an individual with a pre-existing asthma condition. The significance of occupational exposures to these substances may be complicated by evidence that the worker is exposed to such substances in both employment and non-employment settings. In the investigation of the claim, the Board seeks evidence of whether the worker is exposed to any sensitizing

or irritating substances (obtaining where available any material safety data sheets), the nature and extent of employment and non-employment exposure to such substances, and whether there is any correlation between apparent changes in airflow obstruction/responsiveness and exposure to such substances. Additional medical evidence may be available in the form of airflow monitoring, expiratory spirometry, inhalation challenge tests, and skin testing for sensitization.

ii. Pre-Existing Asthma Condition

A pre-existing asthma condition is not compensable unless it has been aggravated by an occupational exposure (i.e. accelerated, activated, or advanced more quickly than would have occurred in the absence of an occupational exposure). A worker is not entitled to compensation where the worker's pre-existing asthma condition is triggered or aggravated by substances which are present in both occupational and non-occupational settings unless the workplace exposure can be shown to have been of causative significance in aggravation of the condition. A speculative possibility that a workplace exposure to such a substance has caused an aggravation of the pre-existing asthma is not enough for the acceptance of a claim.

iii. Temporary Disability

In the case of a compensable asthma or a respiratory tract reaction to a substance with irritating or inflammatory properties, wage-loss benefits are payable until the worker's acute symptoms resolve or stabilize or the worker reaches retirement age as determined by the Board.

iv. Permanent Disability

(a) Work-Caused Asthma

Where workplace exposures have caused the worker to develop asthma (either allergic or irritant-induced) and the worker's acute symptoms do not entirely resolve, so that the worker is left with a permanent impairment of the respiratory system, permanent disability benefits under section 195 may be assessed with reference to the asthma tables in the *Permanent Disability Evaluation Schedule* (See Appendix 3).

(b) Permanent Aggravation of Pre-Existing Asthma

Where workplace exposures have caused a permanent aggravation of the worker's pre-existing asthma, so that the worker is unlikely to return to the worker's pre-exposure state, the Board may provide permanent disability benefits under section 195 after considering the asthma tables in the *Permanent Disability Evaluation Schedule*. In these cases, the Board considers whether proportionate entitlement under section 146 of the *Act* is appropriate. (See Item C6-44.00.)

In the situation described above, no permanent disability benefits are granted to a worker with a pre-existing asthma condition when the worker has returned to the worker's pre-exposure state.

(c) Asthma Due to Sensitization

Where workplace exposures to a sensitizing agent have caused the worker to develop asthma and the worker's acute symptoms resolve following removal from the workplace, the Board may consider the worker to have a permanent impairment where:

- the worker is left with a significant underlying allergy or sensitivity; and as a result
- the worker must avoid workplaces containing the sensitizing agent.

A significant underlying allergy or sensitivity is one where the worker reacts with asthmatic symptoms when exposed to a workplace sensitizing agent. This is indicated by increased bronchial reactivity and/or a significant change in peak flow when the worker returns to the workplace under conditions that do not expose the worker to excessive (i.e. irritant) levels of the sensitizing agent or other known respiratory irritants.

In determining whether there is a need to avoid certain workplaces, the Board considers the medical evidence, including the nature of the sensitization and the likelihood of an asthmatic reaction should the worker return to a work environment containing the sensitizing agent. In making this assessment, the Board considers medical advice from the attending physician and/or Board Medical Advisor.

Where it is found that the worker has a permanent impairment due to a significant underlying allergy or sensitivity, the Board considers the asthma tables found in the *Permanent Disability Evaluation Schedule* to assess the disability rating.

B. ACUTE RESPIRATORY REACTIONS TO SUBSTANCES WITH IRRITATING OR INFLAMMATORY PROPERTIES

Item 9 of Schedule 1 lists "Acute upper respiratory inflammation, acute pharyngitis, acute laryngitis, acute tracheitis, acute bronchitis, acute pneumonitis or acute pulmonary edema, excluding any allergic reaction, reaction to environmental tobacco smoke or effect of an infection", as an occupational disease. The process or industry described in column 2 opposite to it is "Where (a) there is exposure to a high concentration of fumes, vapours, gases, mists or dusts of substances that have irritating or inflammatory properties, and (b) the respiratory symptoms occur within 48 hours of

the exposure or, if there is exposure to nitrogen dioxide or phosgene within 72 hours of the exposure".

There are many agents used in industry and commerce in British Columbia that have irritating or inflammatory properties, and which in sufficient concentrations can produce respiratory symptoms if inhaled. Symptoms associated with the inhalation of such substances can vary from mild transient symptoms (such as a mild burning sensation affecting the eyes, nose and throat) to significant symptoms throughout the respiratory tract (such as dyspnea and respiratory distress). Significant exposure to some substances may result in persistent respiratory symptoms.

Onset of symptoms can occur within a few minutes or several hours of the exposure, depending on the substance. For the presumption in section 137 of the *Act* to apply, the symptoms must appear within 48 hours of the exposure, unless the exposure is to nitrogen dioxide or phosgene, in which case the onset of symptoms must occur within 72 hours.

A claim for compensation made by a worker who has developed persistent or chronic respiratory symptoms considered to be due to exposure to a substance with irritating or inflammatory properties, must be considered on its own individual merits without the benefit of a presumption in favour of work causation (unless the claim meets the requirements of one of the other items of Schedule 1). This includes claims for chronic bronchitis, emphysema, chronic obstructive pulmonary disease, obliterative bronchiolitis, reactive airways dysfunction syndrome (RADS), chronic rhinitis, and conditions considered to be due to exposure to tobacco smoke. The same is true of a claim made by a worker with acute respiratory symptoms where the requirements of section 137 of the *Act* are not met (see policy in Section C. of Item C4-25.20). Where a worker who develops an acute reaction to a substance with irritating or inflammatory properties subsequently develops a persistent or chronic respiratory condition, a decision will be made based on the merits and justice of that claim on whether the chronic condition is a compensable consequence of the acute reaction.

A claim made by a worker who has inhaled a vapour or gas which was at a temperature high enough to cause thermal injury (such as inhaling steam) will be treated as a claim for a personal injury and will be adjudicated in accordance with the policies set out in Chapter 3.

In item 9 of Schedule 1, the words “high concentration” is a recognition that the amount of the particular substance in the air must be significant for the presumption to apply. The manner in which an exposed individual will react will depend on the properties of the substance inhaled (e.g., acidity/alkalinity, chemical reactivity, water solubility, asphyxiating potential) and the amount inhaled. Individual judgment must be exercised in each case to determine whether there was a “high concentration” of the particular substance having regard to the medical and scientific evidence available, including evidence as to the irritating and/or inflammatory properties of that substance.

C. BRONCHITIS AND EMPHYSEMA

Bronchitis and emphysema are recognized as occupational diseases by regulation under section 138(2) of the *Act.*

Bronchitis and emphysema were recognized by regulation as occupational diseases on July 11, 1975. Medical evidence indicates that it would be an extremely rare case where a worker’s employment environment could be shown to be the cause of the bronchitis or emphysema.

Where a person claims compensation in respect of bronchitis or emphysema, the Board considers that a history of heavy or significant cigarette smoking raises a strong inference that the worker’s condition is due to the smoking and not to the nature of the employment. Against this inference must be weighed any evidence which supports the claim, but the inference will not be rebutted where the opposing evidence is weak or conflicting.

The principles set out above do not mean that a worker who has never smoked cigarettes or has smoked an insignificant amount will automatically be compensated for any bronchitis and emphysema. Evidence will still have to be produced that the disease is due to the nature of the employment. The advantage such a worker will have is that a major non-occupational cause of these diseases will have been eliminated.

EFFECTIVE DATE:	July 14, 2025
AUTHORITY:	Sections 136, 137, 138, and Schedule 1 of the *Act.*
CROSS REFERENCES:	Item C4-25.10, *Has a Designated or Recognized Occupational Disease*; Item C4-25.20, *Establishing Work Causation*; C6-44.00, *Proportionate Entitlement*; Appendix 2, Schedule 1; Appendix 3, *Permanent Disability Evaluation Schedule*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	July 14, 2025 – Amendments to ensure consistency for pre-existing diseases as between personal injury and occupational disease claims.

January 1, 2021 – Policy changes made consequential to implementing the permanent partial disability benefits provisions of the *Workers Compensation Amendment Act, 2020* (Bill 23).
September 1, 2020 – Housekeeping change to add the title of Appendix 3 to the Cross Reference section.
April 6, 2020 – This policy resulted from the consolidation of former policy items #29.00, #29.10, #29.20 and #29.30, consequential to the implementation of the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. The principles set out in Section C. were derived from *Workers Compensation Reporter* series Decision No. 207 (1976), 3 W.C.R. 21.
February 1, 2020 – Former policy item #29.20 was amended to provide guidance on legal issues of evidence and causation.
March 1, 2018 – Former policy item #29.20 was consequentially amended as a result of correcting a typographical error in then Schedule B.
May 1, 2017 – Former policy item #29.10 was consequentially amended to reflect the renumbering of former policy item #26.23 (previously #26.22).
January 1, 2007 – Former policy item #29.20 was revised, including to provide that a worker may be considered to have a permanent impairment where the worker is left with a significant underlying allergy or sensitivity and as a result, the worker must avoid workplaces containing the sensitizing agent.
July 16, 2002 – Former policy item #29.20 had a housekeeping change to update terminology.

APPLICATION: Applies to all decisions, including appellate decisions, made on or after July 14, 2025.

RE:	Pneumoconioses and Other Specified Diseases of the Lungs	ITEM:	C4-29.10

BACKGROUND

1. Explanatory Notes

This policy provides guidance for adjudicating pneumoconioses and other specified diseases of the lung.

2. The Act

Section 1, in part:

> **"metalliferous mining industry"** includes the operations of milling and concentrating, but does not include any other operation for the reduction of minerals;
>
> ...
>
> **"silica dust"** means dust containing silica;
>
> **"silicosis"** means a fibrotic condition of the lungs cause by the inhalation of silica dust;
>
> ...

Section 136:

> (1) Compensation is payable under this Part [Part 4 − Compensation to Injured Workers and Their Dependants] in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment, if
>
> (a) as applicable,
>
> (i) the worker has an occupational disease that disables the worker from earning full wages at the work at which the worker was employed, or
>
> (ii) the death of the worker is caused by an occupational disease, and

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

(2) For the purposes of subsection (1), the date of disablement must be treated as the occurrence of the injury.

(3) A health care benefit may be provided for a worker who has an occupational disease referred to in subsection (1)(b) even though the worker is not disabled from earning full wages at the work at which the worker was employed.

Section 137:

(1) This section applies to a worker who is disabled as referred to in section 136(1)(a)(i) as a result of an occupational disease described in column 1 of Schedule 1 of this Act.

(2) If, on or immediately before the date of the disablement, the worker was employed in a process or industry described in column 2 of Schedule 1 opposite the occupational disease that has resulted in the disablement, the occupational disease must be presumed to have been due to the nature of the worker's employment unless the contrary is proved.

Section 141:

(1) Subject to subsection (2),

(a) a worker in the metalliferous mining industry or coal mining industry who becomes disabled from uncomplicated silicosis or from silicosis complicated with tuberculosis is entitled to compensation for total or partial disability as provided under this Part [Part 4], and

(b) if death results from the worker's disability, the worker's dependants are entitled to compensation as provided under this Part [Part 4].

(2) The worker or a dependant of the worker is not entitled to compensation for the disability or death referred to in subsection (1) unless the following apply:

(a) either

(i) the worker has been a resident of British Columbia for a period of at least 3 years immediately before the disablement, or

(ii) at least 2/3 of the worker's exposure to silica dust occurred in British Columbia;

(b) the worker did not have silicosis or tuberculosis before being first exposed to silica dust in the metalliferous mining or coal mining industry in British Columbia;

(c) the worker was exposed to silica dust in the metalliferous mining or coal mining industry in British Columbia

(i) for a period or periods totalling 3 years preceding the worker's disablement, or

(ii) for a shorter period of the worker was not exposed to silica dust anywhere except in British Columbia.

Section 142:

(1) This section applies to compensation in relation to a worker who has sustained a pulmonary injury caused by a disabling form of pneumoconiosis as a result of exposure to dust conditions that the Board considers have contributed to the development of the disease in employment in British Columbia in an industry in which that disease is an occupational disease under this Part.

(2) The worker or a dependant of the worker is entitled to compensation if

(a) the worker did not have either pneumoconiosis or tuberculosis before being first exposed in British Columbia to the dust conditions referred to in subsection (1), and

(b) the worker's residence in British Columbia and exposure to the dust conditions have been of the duration required to entitle a worker to compensation for silicosis under section 141 *[occupational disease – mining industry silicosis]*.

Section 143:

(1) This section applies to a deceased worker who, on the date of the worker's death,

(a) was under 70 years of age, and

(b) had an occupational disease of a type that impairs the capacity of function of the lungs.

(2) If the death was caused by an ailment or impairment of the lungs or heart of non-traumatic origin, it must be conclusively presumed that the death resulted from the occupational disease.

Section 250(1):

If compensation is paid

(a) Under section 141 *[mining industry silicosis]* in relation to a worker who was exposed to the inhalation of silica dust in 2 or more classes or subclasses of industry in British Columbia, or

(b) Under section 142 *[lung disease from exposure to dust conditions]* in relation to a worker who was exposed to dust conditions in 2 or more classes or subclasses of industry in British Columbia,

The Board may apportion the cost of compensation among the funds provided by those classes or subclasses on the basis of the duration and severity of the exposure in each.

POLICY

The guiding legislation in compensation for pneumoconioses is provided in the definition of "silicosis" in section 1, and sections 137, 141, 142, 143 and 250(1) of the *Act*. "Pneumoconiosis" is a general medical term used to describe certain lung diseases due to deposition of particulate matter in the lungs.

Section 142 of the *Act* applies to compensation in relation to "a worker who has sustained a pulmonary injury caused by a disabling form of pneumoconiosis as a result of exposure to dust conditions that the Board considers have contributed to the development of the disease in employment in British Columbia in an industry in which that disease is an occupational disease" under Part 4 of the *Act*.

Section 142(2) states that the worker or a dependant of the worker is entitled to compensation if:

(a) the worker did not have either pneumoconiosis or tuberculosis before being first exposed in British Columbia to the dust conditions referred to in section 142(1) of the *Act* (i.e. dust conditions that the Board considers have contributed to the development of the disease in employment in British Columbia in an industry in which that disease is an occupational disease under Part 4 of the *Act*), and

(b) the worker's residence in British Columbia and exposure to the dust conditions have been of the duration required to entitle a worker to compensation for silicosis under section 141:

(i) either

(A) the worker has been a resident of British Columbia for a period of at least 3 years immediately before the disablement, or

(B) at least 2/3 of the worker's exposure to the dust conditions referred to in section 142(1) occurred in British Columbia;

and

(ii) the worker was exposed to the dust conditions referred to in section 142(1) for either

(A) a period or periods totaling 3 years preceding the worker's disablement, or

(B) for a shorter period if the worker was not exposed to the dust conditions referred to in section 142(1) anywhere except in British Columbia.

Schedule 1 of the *Act* lists five lung diseases as occupational diseases that are presumed to be due to the nature of the worker's employment.

Item 3 of Schedule 1 recognizes three types of pneumoconiosis.

A. SILICOSIS

Item 3(1) of Schedule 1 lists "Silicosis" as an occupational disease. The process or industry described in column 2 opposite to it is "Where there is exposure to airborne silica dust, including in metalliferous mining and coal mining". This latter description does not exclude the presumption from applying to workers exposed to airborne silica dust engaged in employments other than metalliferous mining and coal mining.

By virtue of section 141(a) of the *Act*, a worker in the metalliferous mining industry or coal mining industry who becomes disabled from uncomplicated silicosis or from silicosis complicated with tuberculosis is entitled to compensation for total or partial disability. By virtue of section 141(b), if death results from the worker's disability, the worker's dependants are entitled to compensation. The worker or a dependant of the worker is not entitled to compensation for the disability or death unless the requirements of section 141(2) are met.

The presumption that workers who become disabled from uncomplicated silicosis or from silicosis complicated with tuberculosis when they were exposed to airborne silica dust in the metalliferous mining industry or coal mining industry is limited by the requirements set out in section 141(2) of the *Act*.

i. Meaning of Disabled from Silicosis

The restrictions contained in section 136(1)(a)(i) of the *Act* do not apply to silicosis. It is, therefore, not a requirement of a claim for silicosis that there should be a lessened capacity for work, or that the worker should be disabled from earning full wages at the work at which the worker was employed.

It is a requirement in a claim under section 141 for silicosis that the worker be "disabled" from the silicosis, or from silicosis complicated with tuberculosis. There is no definition of "disability" in the *Act*, and the Board has not attempted any comprehensive definition. If a worker has a condition of an internal organ which is so slight as to be unnoticeable to that person, and which causes no significant discomfort or other ill effects, that is not a "disability".

It can be difficult to fix the date for commencing permanent disability benefits when there is no change of jobs or reduction in earnings to mark the inception of the disability. No general rules can be laid down for this purpose. The Board must decide the question according to the available evidence. However, if the evidence does not clearly establish when the disability commenced, and there is no evidence of the existence of a disability prior to the receipt of a particular medical report, the Board may properly decide that, according to the available evidence, the disability commenced on the date of the medical examination which was the subject of that report.

There may also be a difficulty in fixing the worker's average earnings when such worker is not employed at the time when the disability commenced. The Board should generally refer back to the employment or employments in which the worker was most recently engaged and base any permanent disability benefits on the previous earnings thus discovered.

ii. Exposure to Silica Dust Occurring Outside British Columbia

Where the three criteria set out in section 141(2) of the *Act* are met, there will be no reduction in benefits according to the proportion of exposure to silica dust occurring outside the province versus that within. Unless an agreement entered into pursuant to section 335 of the *Act* supersedes this policy, the Board will therefore pay full compensation to the worker without regard to the extent of exposure to silica dust outside the province.

B. ASBESTOSIS

Item 3(2) of Schedule 1 lists “Asbestosis” as an occupational disease. The process or industry described in column 2 opposite to it is “Where there is exposure to airborne asbestos dust”.

A worker need not necessarily have worked directly with asbestos for the presumption to apply. The exposure may be a secondary exposure, such as working in an area where asbestos was used as insulation which was for years in a friable or decayed condition.

C. OTHER PNEUMOCONIOSES

Item 3(3) of Schedule 1 lists “Other pneumoconioses” as an occupational disease. The process or industry described in column 2 opposite to it is “Where there is exposure to the airborne dusts of coal, beryllium, tungsten carbide, aluminum or other dusts known to produce fibrosis of the lungs”.

D. DIFFUSE PLEURAL THICKENING OR FIBROSIS AND BENIGN PLEURAL EFFUSION

Item 4 of Schedule 1 lists “Diffuse pleural thickening or fibrosis, whether unilateral or bilateral” as an occupational disease. The process or industry described in column 2 opposite to it is “Where there is exposure to airborne asbestos dust and the worker has not previously had and does not currently have collagen disease, chronic uremia, drug-induced fibrosis, tuberculosis or other infection, trauma or disease capable of causing pleural thickening or fibrosis.”

Item 5 of Schedule 1 lists “Benign pleural effusion, whether unilateral or bilateral” as an occupational disease. The process or industry described in column 2 opposite to it is “Where there is exposure to airborne asbestos dust and the worker has not previously had and does not currently have collagen disease, chronic uremia, tuberculosis or other infection, trauma or disease capable of causing pleural effusion.”

These items in Schedule 1 recognize that diffuse pleural thickening or fibrosis whether unilateral or bilateral, and benign pleural effusion, whether unilateral or bilateral, are likely to be due to the nature of the employment of workers exposed to airborne asbestos dust where the other known causes of the disease can be excluded.

E. MESOTHELIOMA

Item 6(4) of Schedule 1 lists “Mesothelioma, whether pleural or peritoneal” as an occupational disease. The process or industry described in column 2 opposite to it is “Where there is exposure to airborne asbestos dust.” Mesothelioma is a malignancy arising from the mesothelial tissue. As with Asbestosis, the exposure to airborne asbestos dust may be a secondary exposure.

EFFECTIVE DATE:	April 6, 2020
AUTHORITY:	Sections 1, 136, 137, 141, 142, and 143 of the *Act.*
CROSS REFERENCES:	Item C4-25.10, *Has a Designated or Recognized Occupational Disease*; Item C4-25.20, *Establishing Work Causation*; Appendix 2, Schedule 1, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2022 – Housekeeping amendment. April 6, 2020 – This policy resulted from the consolidation of former policy items #29.40, #29.41, #29.42, #29.43, #29.45, #29.46, #29.47, and #29.48, consequential to the implementation of the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Former policy item #29.42 was amended to delete references to Board officers.
APPLICATION:	This Item applies to all decisions, including appellate decisions, made on or after April 6, 2020.

RE:	Presumption Where Death Results from Ailment or Impairment of Lungs or Heart	ITEM:	C4-29.20

BACKGROUND

1. Explanatory Notes

This policy sets out the legislative presumption regarding death caused by the ailment or impairment of lungs or heart.

2. The Act

Section 143:

(1) This section applies to a deceased worker who, on the date of the worker's death,

(a) was under 70 years of age, and

(b) had an occupational disease of a type that impairs the capacity of function of the lungs.

(2) If the death was caused by an ailment or impairment of the lungs or heart of non-traumatic origin, it must be conclusively presumed that the death resulted from the occupational disease.

POLICY

Section 143 of the *Act* does not apply to deaths occurring before July 1, 1974.

The question whether the deceased worker had an ". . . occupational disease of a type that impairs the capacity of function of the lungs" is not determined by the failure or success of any claim made in the deceased worker's lifetime. Thus, the Board can decide that there was such a disease at the date of death, even though it disallowed a claim made by the worker in respect of that disease. Alternatively, it can now conclude that there is no such disease, notwithstanding it accepted a claim made by the worker before the worker's death in respect of the same condition. This can well happen because often there is new evidence available following a death, typically in the form of an autopsy report which may be the best evidence available.

Once the age of the worker and the conditions set out in section 143 have been established, it is conclusively presumed that the death resulted from the occupational disease. This presumption cannot be rebutted by contrary evidence.

If the deceased worker was 70 years of age or over, or for some other reason the presumption cannot be applied, medical and other evidence must be examined to determine whether the death resulted from the occupational disease.

EFFECTIVE DATE:	April 6, 2020
AUTHORITY:	Section 143 of the *Act.*
CROSS REFERENCES:	Item C4-25.20, *Establishing Work Causation*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 – This policy replaces former policy item #29.50, consequential to the implementation of the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
APPLICATION:	This Item applies to all decisions, including appellate decisions, made on or after April 6, 2020.

RE: Cancers	ITEM: C4-30.00

BACKGROUND

1. Explanatory Notes

This policy provides guidance for adjudicating bladder cancer and gastro-intestinal cancer.

2. The Act

Section 136:

(1) Compensation is payable under this Part [Part 4 − Compensation to Injured Workers and Their Dependants] in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment, if

(a) as applicable,

(i) the worker has an occupational disease that disables the worker from earning full wages at the work at which the worker was employed, or

(ii) the death of the worker is caused by an occupational disease, and

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

(2) For the purposes of subsection (1), the date of disablement must be treated as the occurrence of the injury.

(3) A health care benefit may be provided for a worker who has an occupational disease referred to in subsection (1)(b) even though the worker is not disabled from earning full wages at the work at which the worker was employed.

Section 137:

(1) This section applies to a worker who is disabled as referred to in section 136(1)(a)(i) as a result of an occupational disease described in column 1 of Schedule 1 of this Act.

(2) If, on or immediately before the date of the disablement, the worker was employed in a process or industry described in column 2 of Schedule 1 opposite the occupational disease that has resulted in the disablement, the occupational disease must be presumed to have been due to the nature of the worker's employment unless the contrary is proved.

Section 138, in part:

(3) The Board may, by order, designate or recognize a disease as an occupational disease in a specific case.

(4) The Board may designate or recognize a disease as being a disease that is peculiar to or characteristic of a particular process, trade or occupation, on the terms and conditions and with the limitations set by the Board.

Schedule 1:

See Appendix 2.

POLICY

Mesothelioma is covered in Section E. of Item C4-29.10.

A. BLADDER CANCER

Item 6(10) of Schedule 1 lists "Primary cancer of the epithelial lining of the urinary bladder, ureter or renal pelvis" as an occupational disease. The process or industry described in column 2 opposite to it is "Where there is prolonged exposure to beta-naphthylamine, benzidine or 4-nitrodiphenyl". In adjudicating a claim for bladder cancer it is incumbent on the Board to assess whether the worker has had prolonged exposure to any of the substances listed in Item 6(10) of Schedule 1.

In addition to the chemicals listed in column 2 of Schedule 1, the Board recognizes that aluminum smelter workers exposed to coal tar pitch volatiles have an increased incidence of bladder cancer.

Claims for bladder cancer from aluminum smelter workers which do not meet the descriptions contained in column 2 of Schedule 1 are adjudicated on the basis of

cumulative (or total) exposure to benzo-a-pyrene, a constituent of coal tar pitch volatiles. In the adjudication of such a claim the following principles and procedures apply:

1. If the disease develops within 10 years of a worker's first exposure to benzo-a-pyrene, it will not normally be considered to have resulted from that exposure.

2. In determining the severity of a worker's exposure, regard will, where the information is available, be given to the following ranking of exposure:

Ranking of Exposure	Exposure to B.S.M. (mg/m^3)
Zero	0
Low	0.1
Medium	0.6
High	1.5

B.S.M. refers to benzene-soluble materials.

3. To determine a worker's total occupational exposure, the years which the worker has spent in each job will be multiplied by the concentration of B.S.M. determined for that job by the rankings referred to above. For example, five years in a high risk job will produce a total exposure to B.S.M. of 7.5 mg/m^3 years (5 multiplied by 1.5). The worker's total or cumulative exposure to benzene-soluble materials is the sum of the exposures calculated for each job.

   Any exposure which occurred in the 10 years immediately preceding the date the bladder cancer was first diagnosed shall be excluded from this calculation.

4. To convert benzene-soluble materials exposure to benzo-a-pyrene exposure, the worker's total exposure to benzene-soluble materials (expressed in milligrams per cubic metre years or mg/m^3 years) is multiplied by 11.0. The result (total or cumulative benzo-a-pyrene exposure) is expressed in micrograms per cubic metre years or $\mu g/m^3$ years.

5. The worker's relative risk of having developed bladder cancer as a result of the worker's employment in the aluminum smelter is then determined by comparing the worker's cumulative exposure to benzo-a-pyrene

(calculated in accordance with the above principles) with the relative risk figures contained in the following table:

Cumulative Exposure to Benzo-a-pyrene	Relative Risk
0	1.00
5	1.16
10	1.32
15	1.48
20	1.64
25	1.80
30	1.96
31.25	2.00
35	2.12
40	2.28
45	2.44
50	2.60
60	2.92
70	3.24
80	3.56
90	3.88

Note: These numbers take into account scientific uncertainty and are based on the upper 95% confidence limit of the exposure-response relationship.

Where the worker's corresponding relative risk is equal to 2.00 or greater, it will be considered that the bladder cancer resulted from such employment and the claim will be accepted.

6. Where, having applied the above principles, the worker's relative risk is less than 2.00, or where the information necessary to calculate the worker's relative risk is not available, a detailed investigation will be carried out by the Board into the worker's job history to determine whether the level of exposure assessed for that worker is reasonable. Relevant considerations may include special work assignments, hours of overtime, individual work practices, and any other characteristics of the workplace or work environment which may have had an impact on the duration and intensity of the exposure. If, following this investigation, it is concluded that the worker's relative risk is less than 2.00, it will be considered that

the bladder cancer is not due to the worker's employment in the aluminum smelter and the claim will be disallowed.

7. Where the employer and the worker, through the worker's union, reach an agreement as to the total exposure of the worker to benzene-soluble materials in mg/m^3 years or to benzo-a-pyrene in $\mu g/m^3$ years, the Board is not bound to accept this amount and may follow the investigation and determination procedures outlined above. The amount agreed by the employer and the union may, however, be accepted in lieu of the investigation and determination procedures set out above if the agreed amount appears reasonable in the known circumstances of the case.

8. Smoking is a strong non-occupational risk factor for bladder cancer. Smoking and exposure to benzo-a-pyrene act synergistically in increasing the risk of developing bladder cancer. If the worker's relative risk calculated in accordance with the above principles is 2.00 or greater, the worker's smoking history will not change the conclusion that the bladder cancer was due to the employment.

B. GASTROINTESTINAL CANCER

Item 6(6) of Schedule 1 lists "Gastrointestinal cancer, including all primary cancers associated with the esophagus, stomach, small bowel, colon and rectum excluding the anus, and without regard to the site of the cancer in the gastrointestinal tract or the histological structure of the cancer", as an occupational disease. The process or industry described in column 2 opposite to it is "Where there is exposure to asbestos dust if, during the period between the first exposure to asbestos dust and the diagnosis of gastrointestinal cancer, there has been a period of, or periods adding up to, 20 years of continuous exposure to asbestos dust and such exposure represents or is a manifestation of the major component of the occupational activity in which the exposure occurred."

A worker's gastrointestinal cancer will not normally be considered to be due to the worker's employment if the worker has not been exposed to asbestos fibres in the course of the worker's employment, or the worker's exposure to such fibres does not substantially have the duration, continuity and extent described in column 2 of Schedule 1.

If there have been fewer than 20 years of continuous exposure to asbestos fibres, such that the presumption in section 137 does not apply, but there has been substantial compliance with the requirements of column 2 of Schedule 1, the Board will consider whether the evidence indicates that the gastrointestinal cancer is due to the nature of the worker's employment under section 138(3) of the *Act*. Whether or not the compliance is substantial is a matter of judgment for the Board. The greater the gap between the worker's period of exposure and the 20-year period, the less likely is the

compliance to be substantial and the less likely is the disease to be due to the nature of the employment.

EFFECTIVE DATE:	April 6, 2020
AUTHORITY:	Sections 136, 137, 138, and Schedule 1 of the *Act.*
CROSS REFERENCES:	Item C4-25.10, *Has a Designated or Recognized Occupational Disease*; Item C4-25.20, *Establishing Work Causation*; Item C4-29.10, *Pneumoconioses and Other Specified Diseases of the Lungs*; Appendix 2, Schedule 1, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 – This policy resulted from the consolidation of former policy items #30.00, #30.10, and #30.20, consequential to the implementation of the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. The principles set out in Section B were derived from *Workers Compensation Reporter* series Decision No. 232 (1977), 3 W.C.R. 91. June 1, 2009 – Former policy items #30.10 and #30.20 were amended to delete references to Board officers.
APPLICATION:	This Item applies to all decisions, including appellate decisions, made on or after April 6, 2020.

RE: Hearing Loss	ITEM: C4-31.00

BACKGROUND

1. Explanatory Notes

This policy provides guidance in adjudicating non-traumatic hearing loss.

2. The Act

Section 145:

(1) A worker is entitled to compensation under this Part if

(a) the worker has a hearing loss of non-traumatic origin that arose out of and in the course of employment to which the compensation provisions apply, and

(b) the hearing loss

(i) was sustained by exposure to causes of hearing loss in British Columbia, and

(ii) is a greater loss than the minimum set out in Schedule 2 *[Non-Traumatic Hearing Loss]* of this Act.

(2) An application for compensation under this section must be accompanied or supported by a specialist's report and audiogram or by other evidence of hearing loss that the Board prescribes.

(3) The Board may, by regulation, amend Schedule 2 in respect of the following:

(a) the ranges of hearing loss;

(b) the percentages of disability, including the maximum percentages of total disability;

(c) the methods or frequencies to be used to measure hearing loss.

Section 195:

(1) Subject to section 196, if a permanent partial disability results from a worker's injury, the Board must

(a) estimate the impairment of the worker's earning capacity from the nature and degree of the injury, and

(b) pay the worker compensation that is a periodic payment of an amount that equals 90% of the Board's estimate of the worker's loss of average net earnings resulting from the impairment.

(2) The minimum compensation to be paid under this section must be calculated in accordance with section 191(2) *[compensation for temporary total disability]* but to the extent only of the permanent partial disability.

(3) The Board may compile a rating schedule of percentages of impairment of earning capacity for specified injuries or mutilations that may be used as a guide in determining the compensation payable in permanent partial disability cases.

Section 196:

(1) This section applies in relation to a permanent partial disability if an amount required under section 195 is less than an amount required under this section.

(2) *Repealed*.

(3) The Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the difference between

(a) the average net earnings of the worker before the injury, and

(b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:

(i) the average net earnings that the worker is earning after the injury;

(ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury.

Section 198:

(1) This section applies in relation to compensation payable to a worker under section 145 *[non-traumatic hearing loss]*.

(1.1) If there is no loss of earnings resulting from the worker's hearing loss, the compensation payable to the worker is the amount determined under subsection (2) or (3).

(2) If the worker's hearing loss amounts to a complete loss of hearing, measured in the manner described in Schedule 2 [*Non-Traumatic Hearing Loss*] of this Act, the compensation is the amount calculated as if for a disability equivalent to the maximum percentage of total disability specified in that Schedule.

(3) If the worker's hearing loss does not amount to a complete loss of hearing, measured in the manner described in Schedule 2 of this Act, the compensation

(a) must be less than the amount of compensation determined under subsection (2) of this section, and

(b) unless otherwise ordered by the Board, is the amount calculated as if for a disability equivalent to the percentage of total disability determined in accordance with Schedule 2.

(4) If a loss of earnings results from the hearing loss, the worker is entitled to compensation for a total or partial disability as otherwise provided under this Division.

(5) Compensation paid for a worker's hearing loss under subsection (4) must not be less than the amount determined under subsection (2) or (3).

Section 201:

(1) Subject to subsection (2), periodic payment of compensation under this Division may be paid to an injured worker only as follows:

(a) if the worker is under 63 years of age on the date of the injury, until the later of the following:

(i) the date the worker reaches 65 years of age;

(ii) if the Board is satisfied the worker would retire after reaching 65 years of age, the date the worker would retire, as determined by the Board;

(b) if the worker is 63 years of age or older on the date of the injury, until the later of the following:

(i) 2 years after the date of the injury;

(ii) if the Board is satisfied that the worker would retire after the date referred to in subparagraph (i), the date the worker would retire, as determined by the Board.

(2) As a restriction on subsection (1), the Board may not make a periodic payment to a worker under this Division if the worker ceases to have the disability for which the periodic payment is to be made.

(3) A determination made under subsection (1) (a) (ii) as to a date on which a worker would retire after reaching age 65 may be made after a worker has reached age 63, and the Board may, when making the determination, consider the worker's circumstances at the time of that determination.

Section 226:

Compensation is not payable to a worker under section 145 *[non-traumatic hearing loss]*

(a) in respect of a period before September 1, 1975, or

(b) if the worker's exposure to causes of hearing loss in British Columbia ended before that date.

Section 250(2):

If compensation is paid under section 145 *[non-traumatic hearing loss]* in relation to a worker's hearing loss caused by exposure to causes of hearing loss in 2 or more classes or subclasses of industry in British Columbia, the Board may apportion the cost of compensation among the funds provided by those classes or subclasses on the basis of the duration or severity of the exposure in each.

Schedule 1, Item 12:

See Appendix 2.

Schedule 2:

SCHEDULE 2

Non-Traumatic Hearing Loss

Interpretation of table

1 In the table in this Schedule,

(a) a range of decibels set out in column 1 reflects hearing loss measured in accordance with section 2 of this Schedule,

(b) a percentage of disability set out in column 2 opposite a range of decibels set out in column 1 is the percentage of disability for the ear most affected by the hearing loss, and

(c) a percentage of disability set out in column 3 opposite a range of decibels set out in column 1 is the percentage of disability for the ear least affected by the hearing loss.

Measuring hearing loss

2 (1) Loss of hearing is measured

(a) by calculating the average of the threshold of hearing in each ear measured at the frequencies of 1 000, 2 000, 3 000 and 4 000 Hertz, in turn, by pure-tone air- or bone-conduction audiometry, and

(b) using an audiometer calibrated by a facility that meets the requirements established by the Board.

(2) For the purposes of section 198 (2) of this Act, a loss of hearing in the range of decibels set out in column 1 of item 11 of the table in this Schedule constitutes a complete loss of hearing.

Percentage of total disability

3 For the purposes of section 198 of this Act,

(a) the percentage of total disability is the sum of the percentage of disability for the ear most affected by the hearing loss and the percentage of disability for the ear least affected by the hearing loss,

(b) the maximum percentage of total disability for a complete loss of hearing in one ear and no loss of hearing in the other ear is 6%, and

(c) the maximum percentage of total disability for a complete loss of hearing in both ears is 36%.

TABLE

Item	Column 1 **Range of Hearing Loss (decibels)**	Column 2 **Percentage of Disability for Ear Most Affected**	Column 3 **Percentage of Disability for Ear Least Affected**
1	0-34	0	0
2	35-39	0.3	1.5
3	40-44	1.0	5.0
4	45-49	1.7	8.5
5	50-54	2.3	11.5
6	55-59	3.0	15.0
7	60-64	3.7	18.5
8	65-69	4.3	21.5
9	70-74	5.0	25.0
10	75-79	5.7	28.5
11	80 or more	6.0	30.0

POLICY

A. GENERAL

There are two bases on which compensation can be paid for hearing loss:

(a) If the hearing loss is traumatic and work-related, compensation is paid as with any other injury under section 134(1) and, if a permanent disability results, permanent disability benefits under section 195 may be paid in accordance with the scale provided for in Appendix 3, the *Permanent Disability Evaluation Schedule* (for hearing loss that is secondary to an injury see Item C3-22.00).

(b) If the hearing loss has developed gradually over time as a result of exposure to occupational noise, it is treated as an occupational disease. As set out in section 226 of the *Act*, claims for workers whose exposure to causes of hearing loss in British Columbia ended before September 1, 1975 are adjudicated under section 136 of the *Act.* In all other cases, section 145 of the *Act* applies. If the provisions of section 136 of the *Act* apply to the claim, the worker may be entitled to health care benefits in the form of hearing aids even if they were not disabled from earning full wages at the work at which they were employed (see Item C4-25.30).

Section 145 provides that a worker is entitled to compensation if "the worker has a hearing loss of non-traumatic origin that arose out of and in the course of employment . . .," and the hearing loss "is a greater loss than the minimum set out in Schedule 2" of the *Act*.

Item 12 of Schedule 1 lists "Neurosensory hearing loss" as an occupational disease. Medical research indicates that it is only hearing loss of a neurosensory nature which is caused by exposure to noise over time (although this type of hearing loss may also result from other causes unrelated to exposure to noise). As a result, the Board's responsibility is limited to compensating workers for occupationally-induced neurosensory hearing loss. This is further emphasized in section 145 of the *Act* which requires that the hearing loss be of non-traumatic origin and that it arise out of and in the course of employment.

In situations where a hearing loss is partly due to causes other than occupational noise exposure, the total hearing impairment is initially measured using pure tone air conduction pursuant to Schedule 2. Having done this, in order to comply with the *Act*, other measures, such as bone conduction tests, are carried out to assess the portion of the total loss which is neurosensory and the portion which is due to other causes.

Having made this determination, the factual evidence on the claim is then assessed to determine whether all, or only part of, the neurosensory loss is due to occupational exposure to causes of hearing loss in British Columbia as required by the *Act*. The hearing loss is due to exposure to occupational noise in British Columbia if the worker's employment in British Columbia was of causative significance in the worker's hearing loss. Causative significance means more than a trivial or insignificant aspect.

The resulting portion of the worker's total impairment is then assessed for permanent disability benefits under section 198 of the *Act.* When there is no loss of earnings resulting from the hearing loss, disability benefits under section 198 must be made with reference to the percentage ranges listed in Schedule 2.

Tinnitus is a symptom that is commonly associated with noise-induced hearing loss. Tinnitus is not a personal injury or occupational disease in and of itself. Tinnitus may be compensable where it is:

- a compensable consequence of an accepted claim for noise-induced hearing loss (see Item C3-22.00); and
- confirmed based on evaluation by a qualified person, such as an audiologist.

The Board assesses any permanent disability from tinnitus using a Board-approved subjective reporting scale that has been validated in the evidence-based literature, such as the Tinnitus Handicap Inventory. The Board uses the worker's score on the scale to assess the worker's disability under section 195 of the *Act* with reference to the following table:

Score (%)	Disability (%)
0	0
1 – 20	1
21 – 40	2
41 – 60	3
61 – 80	4
81 – 100	5

B. DATE OF COMMENCEMENT OF SECTION 145

Section 145 expressly applies only to hearing loss of non-traumatic origin which can only mean loss of hearing over some period of time as a cumulative effect. Therefore, "ended" as used in section 226 means the end once and for all of a course of exposure to causes of hearing loss. Exposure is not ended as long as the worker continues to undergo exposure arising out of and in the course of the worker's employment in British Columbia, no matter how intermittent or how far apart periods of exposure might be. Only retirement or other cessation from employment in industries which expose the worker to causes of hearing loss qualify as "ended". Subsequent exposure for any period of time in bona fide employment allows for consideration of compensation under section 145.

Only exposure to noise in industries under the compensation provisions of the *Act* after September 1, 1975 should be considered to determine whether or not a worker qualifies for compensation under section 145.

If a worker's exposure to causes of hearing loss ended prior to September 1, 1975, no compensation is payable under section 145 whatever may be the reasons for the ending of the worker's exposure. No exception can be made if, for instance, the end came about because a previous compensable injury forced the worker to leave the worker's employment. A worker whose exposure ceased prior to September 1, 1975 may be entitled to health care (hearing aids) under section 136 of the *Act*.

C. AMOUNT AND DURATION OF NOISE EXPOSURE REQUIRED BY SECTION 145

A claim is acceptable where, as a minimum, evidence is provided of continuous work exposure in British Columbia for two years or more at eight hours per day at 85 dBA or more, and the Board determines the worker's hearing loss is due to exposure to occupational noise. The Board considers it reasonable to set the 85 dBA minimum standard for compensation purposes and then to allow discretion for the acceptance of claims where the evidence supports a finding that the worker is extraordinarily susceptible and has been affected by exposure to noise at a lesser level.

The Board does not accept evidence of the wearing of individual hearing protection as a bar to compensation. However, in the case of noise-reducing enclosures, where evidence shows that the enclosure was used regularly and was generally effective, it may be difficult to accept that the work environment in question contributed to the hearing loss demonstrated.

Where the exposure to occupational noise in British Columbia is less than 5% of the overall exposure experienced by the worker, the claim is disallowed. Such a minimal degree of exposure is insufficient to warrant acceptance of the claim. Where the exposure to occupational noise in British Columbia is 90% or greater of the total exposure, a claim is allowed for the total hearing loss suffered by the worker. For percentages between 5 and 90, the claim is allowed for only that percentage of the hearing loss which is attributable to occupational noise in British Columbia, and the Board will accept responsibility for all health care benefit costs related to the total hearing loss including the provision of hearing aids.

Occupational noise-induced hearing loss occurs first and predominantly at 3 000 to 6 000 Hertz, and typically increases most rapidly in the first 10 to 15 years of exposure. After the first 10 to 15 years, the contribution of continued occupational noise exposure to a worker's hearing loss decelerates progressively to a clinically negligible rate of change. Generally, it is not expected that hearing loss will continue to worsen as a result of occupational noise exposure after approximately 15 years of such exposure. Occupational noise-induced audiometric hearing loss does not progress once hazardous occupational noise exposure has ceased. Since the disability assessment under Schedule 2 of the *Act* relies on frequencies of 1 000, 2 000, 3 000 and 4 000 Hertz, no adjustments for duration of exposure are made.

D. APPLICATION FOR COMPENSATION UNDER SECTION 145

Section 145(2) provides that "An application for compensation under this section must be accompanied or supported by a specialist's report and audiogram or by other evidence of hearing loss that the Board prescribes".

Where a worker has already applied for compensation for hearing loss under section 136, a separate application under section 145 may sometimes be required. However, it will not be insisted upon if it serves no useful purpose. Therefore, no separate application need be made where all the evidence necessary to make a reasonable decision is available without it.

The original application need not be accompanied by a report and audiogram by a physician outside the Board. The Board will obtain the necessary medical evidence.

E. AMOUNT OF COMPENSATION UNDER SECTION 198

No wage-loss benefits are paid to workers who have non-traumatic hearing loss.

Workers who develop non-traumatic noise induced hearing loss are, subject to the time periods referred to in section 201(1) of the *Act*, assessed for permanent disability benefits under section 198 of the *Act*.

Hearing loss permanent disability benefits are determined on the basis of audiometric testing evaluated or conducted by a Board Audiologist Advisor or on the basis of prior audiometric tests conducted closer in time to when the worker was last exposed to hazardous occupational noise if in the Board's opinion the results of such earlier tests best represent the true measure of the worker's hearing loss which is due to exposure to occupational noise.

Section 145(3) of the *Act* provides:

> The Board may, by regulation, amend Schedule 2 in respect of the following:
>
> (a) the ranges of hearing loss;
> (b) the percentages of disability, including the maximum percentages of total disability;
> (c) the methods or frequencies to be used to measure hearing loss.

If the worker's hearing loss amounts to a complete loss of hearing, measured in the manner described in Schedule 2 of the *Act*, and there is no loss of earnings resulting from the hearing loss, section 198(2) provides that compensation is the amount calculated as if for a disability equivalent to the maximum percentage of total disability specified in that Schedule.

If the worker's hearing loss does not amount to complete loss of hearing, and there is no loss of earnings resulting from the hearing loss, section 198(3) provides that compensation must be less than the amount of compensation determined under section 198(2), and, unless otherwise ordered by the Board, is the amount calculated as if for a disability equivalent to the percentage of total disability determined in accordance with Schedule 2.

In assessing permanent disability benefits under section 198, there is no automatic allowance for presbycusis. In some cases, however, the existence of presbycusis may be relevant in deciding whether the worker has a hearing loss due to the worker's employment. The age adaptability factor is not applied to non-traumatic hearing loss compensation made under section 198.

Where a worker has an established history of exposure to noise at work, and where there are other non-occupational causes or components in the worker's hearing loss, and where this non-occupational component cannot be accurately measured using audiometric tests, then the ISO 1999:2013: *Acoustics — Estimation of noise-induced hearing loss* Standard (ISO Standard), as amended from time to time, will apply. The ISO Standard will only be applied where there is some evidence of non-occupational causes or components in the worker's hearing loss (for example, some underlying disease) and will not be applied when the measured hearing loss is greater than expected and there is only a speculative possibility without evidential support that this additional loss is attributable to non-occupational factors.

In some cases, it will be found that a worker already has conductive hearing loss in one ear, unrelated to their work, which might well have afforded some protection against work-related noise-induced hearing loss in that ear. The normal practice in this situation would be to allocate the higher measure in Schedule 2 (the "ear least affected" column) to the other ear which has the purely noise-induced hearing loss.

A difficulty occurs where the worker is not employed at the time when the worker's disability commenced. If there are no current earnings on which to base the permanent disability benefits, the Board should generally refer back to the employments in which the worker was most recently engaged and base the amount on the worker's previous earnings thus discovered.

Based on the principles set out in section 201 of the *Act*, if the worker is retired and under the age of 63 years as of the commencement of the non-traumatic hearing loss permanent disability benefits, periodic payments are made until the date the worker reaches 65 years of age. If the worker is retired and is 63 years of age or older as of the commencement of the non-traumatic hearing loss benefits, periodic payments are made for two years following such date. See Item C6-41.00.

F. CALCULATING COMPENSATION FOR NON-TRAUMATIC HEARING LOSS

Compensation under section 198 of the *Act* is not payable simply because a worker changes employment in order to preclude the development of hearing loss. As with any other occupational disease, there must be functional impairment from the disease before there can be compensation. In other words, compensation is payable for a disability that has been incurred, not for the prevention of one that might occur.

If a noise-induced hearing loss has been incurred, and a worker then changes employment to a lower paid but quieter job, that may trigger consideration by the Board of a permanent disability assessment notwithstanding that it may seem reasonable that with hearing protection, the worker may have stayed at the former employment. There is no obligation to stay in the employment with hearing protection rather than take lower paying work and claim compensation. The drop in earnings may be the triggering device that renders the worker eligible for compensation, but it may not be part of the formula for calculating the amount.

The duration of entitlement to permanent disability periodic payments is established under section 201(1) of the *Act* and discussed in Item C6-41.00.

G. REOPENINGS OF SECTION 198 PERMANENT DISABILITY COMPENSATION DECISIONS

Where the hearing loss is retested for a worker in receipt of permanent disability benefits under section 198 on or after June 30, 2002 and there is a significant change in the worker's hearing, the following applies:

1. If the retest records a deterioration in the worker's hearing and the new findings warrant an increase under Schedule 2 of the *Act*, the permanent disability decision is reopened and the amount is increased.

2. If the retest shows an improvement in the worker's hearing of a degree greater than 10 decibels, the worker's permanent disability decision is reopened. Where this occurs, two further considerations would apply.

    (a) If the worker has been paid the permanent disability benefits in the form of a lump-sum payment, the worker is advised in writing that the worker's hearing has improved to the point where such a payment would no longer appear justified or appropriate. However, in those cases, no attempt is made by the Board to seek a refund.

    (b) If the worker's permanent disability benefits are being paid in the form of a monthly periodic payment, the payments are reduced or terminated, whichever is applicable, and the worker is informed in writing of the reasons and of the right to request a review of the decision by the Review Division.

If the retest suggests there is an improved level of hearing than that upon which the original permanent disability benefit amount was set, but the improvement is within a range up to and including 10 decibels, the permanent disability decision is not reopened.

A worker who has ceased to have entitlement to permanent disability benefits in accordance with the provisions of section 201(1) of the *Act* (see Item C6-41.00) will not be retested by the Board.

H. COMPENSATION FOR NON-TRAUMATIC HEARING LOSS UNDER SECTION 136

A worker will only be entitled to compensation for non-traumatic hearing loss under section 136(1) if the worker's exposure to causes of hearing loss ended prior to September 1, 1975.

Item 12 of Schedule 1 lists "Neurosensory hearing loss" as an occupational disease. The process or industry described in column 2 opposite to it is "Where there is prolonged exposure to excessive noise levels".

Sections 151 and 152 of the *Act* set out the time limits within which an application for compensation must be filed.

If a worker's exposure to causes of hearing loss ended prior to January 1, 1974, the one-year time period to file an application for compensation does not begin to run until the worker becomes disabled from earning full wages within the meaning of section 136(1). If a case exists where a worker's exposure to causes of hearing loss ended prior to January 1, 1974, and no disablement within the meaning of section 136(1) has yet occurred, health care benefits can always be provided, whether or not an application for compensation has been received from the worker and regardless of the length of time which has elapsed since the worker's exposure ended. Once the disablement from earning full wages occurs, the worker then has one year to submit an application for compensation (if the worker has not already done so) or proof of disablement. If no application for compensation or proof of disablement has been received by the end of this period, the worker's claim becomes completely barred even though the worker may previously have received compensation in the form of health care. If the worker submits proof of disablement, but no application for compensation, by the end of this period only compensation in the form of health care is payable.

I. COMMENCEMENT OF PERMANENT DISABILITY PERIODIC PAYMENTS UNDER SECTIONS 136 AND 145

The following applies to claims for hearing loss of non-traumatic origin.

1. If compensation is being paid under section 136, then, subject to sections 151 and 152, permanent disability benefits are calculated to commence as of the date on which the worker first became disabled from earning full wages at the work at which the worker was employed.

2. If compensation is being paid under section 198(4) in respect of a loss of earnings that results from the worker's hearing loss, then, subject to sections 151 and 152, permanent disability benefits are calculated to commence as of the date when the worker first experiences such loss of earnings, or as of September 1, 1975, whichever is the later.

3. If compensation is being paid under section 198(2) or (3) where there is no loss of earnings or impairment of earning capacity, then, subject to sections 151 and 152, permanent disability benefits shall be calculated to commence as of the earlier of either the date of application or the date of first medical evidence that is sufficiently valid and reliable for the Board to establish a compensable degree of hearing loss under Schedule 2 of the *Act*. If the date of application is used as the commencement date, subsequent testing must support a compensable degree of hearing loss as of the date of application. Section 226 provides that in no case will compensation for non-traumatic hearing loss commence prior to September 1, 1975.

EFFECTIVE DATE:	May 15, 2023
AUTHORITY:	Sections 145, 195, 196, 198, and 226 of the *Act.*
CROSS REFERENCES:	Item C3-22.00, *Compensable Consequences*; Item C4-25.30, *Disabled from Earning Full Wages at Work*; Item C6-41.00, *Duration of Permanent Disability Periodic Payments*; Appendix 3, *Permanent Disability Evaluation Schedule*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	May 15, 2023 – Policy amended to reflect amendments to Schedule 2 of the *Act*. Additional policy changes made to reflect the current scientific and medical literature on estimating occupational noise-induced hearing loss, and how noise-induced hearing loss progresses over time. November 24, 2022 – Housekeeping changes consequential to implementing the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41).

January 1, 2021 – Policy changes made consequential to implementing the permanent partial disability benefits provisions of the *Workers Compensation Amendment Act, 2020* (Bill 23).
October 21, 2020 – Amended to reflect amendment to health care provisions of the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020.
April 6, 2020 – This policy resulted from the consolidation of former policy items #31,00, #31,10, #31.20, #31.30, #31.40, #31.50, #31.60, #31.70, and #31.80, consequential to the implementation of the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. Former policy item #31.70 was substantively amended as it had been based on section 55(4) of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, which was deemed spent.
February 1, 2020 – Former policy items #31.00, #31.20 and #31.40 were amended to provide guidance on the legal issues of evidence and causation.
June 1, 2012 – Former policy item #31.00 was amended to provide that permanent disability compensation for tinnitus is available where tinnitus is a compensable consequence of noise-induced hearing loss, in the range of 0% to 5% of total disability when assessed under the loss of function method.
June 1, 2009 – Former policy item #31.40 was amended to delete references to Board officers.
December 1, 2004 – Former policy item #31.20 was amended to update and clarify policy and to remove an ambiguity regarding the jurisdictional requirement for the minimum occupational noise exposure duration threshold.
August 1, 2003, Former policy item #31.40 was amended to change disability rating for complete loss of hearing in one ear with no loss in the other; revisions also made to the frequencies at which hearing loss is to be measured.
March 3, 2003 – Former policy item #31.30 was consequentially amended to implement the *Workers Compensation Amendment Act (No. 2), 2002* (Bill 63 of 2002) by deleting references to appeal and reconsideration. Former policy item #31.60 was similarly consequentially amended regarding references to reopening, review, and the Review Division.
July 16, 2002 – Former policy item #31.40 amended to add reference to duration of permanent disability periodic payments, then section 23.1 of the *Act*, and policy item #41.00.

APPLICATION: Applies to all decisions made on or after May 15, 2023.

RE: Other Matters	ITEM: C4-32.00

BACKGROUND

1. Explanatory Notes

This policy provides guidance in other matters relating to occupational disease.

2. The Act

Section 136, in part:

(1) Compensation is payable under this Part [Part 4 − Compensation to Injured Workers and Their Dependants] in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment, if

(a) as applicable,

(i) the worker has an occupational disease that disables the worker from earning full wages at the work at which the worker was employed, or

(ii) the death of the worker is caused by an occupational disease, and

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

...

Section 137:

(1) This section applies to a worker who is disabled as referred to in section 136(1)(a)(i) as a result of an occupational disease described in column 1 of Schedule 1 of this Act.

(2) If, on or immediately before the date of the disablement, the worker was employed in a process or industry described in column 2 of Schedule 1 opposite the occupational disease that has resulted in the disablement, the occupational disease must be presumed to have been due to the nature of the worker's employment unless the contrary is proved.

Schedule 1:

See Appendix 2.

POLICY

A. CONTACT DERMATITIS

Item 16 of Schedule 1 lists “Contact dermatitis” as an occupational disease. The process or industry described in column 2 opposite to it is “Where there is excessive exposure to irritants, allergens or sensitizers ordinarily causative of dermatitis”.

1. Evidence of Exposure

There are many substances that may either cause contact dermatitis in a previously healthy individual or aggravate or activate a dermatological reaction in an individual with a pre-existing dermatitis condition. The significance of occupational exposures to these substances may be complicated by evidence that the worker is exposed to them in both occupational and non-occupational settings.

When investigating these claims, the Board seeks evidence on whether the worker is exposed to any sensitizing or irritating substances, obtaining where available any material safety data sheets. The Board gathers evidence on the nature and extent of occupational and non-occupational exposure to such substances, and whether there is any correlation between dermatological reactions and exposure. The Board also seeks medical evidence, for instance skin patch testing for sensitization.

2. Pre-existing Contact Dermatitis Condition

A pre-existing contact dermatitis condition is not compensable unless it has been aggravated by an occupational exposure (i.e. accelerated, activated, or advanced more quickly than would have occurred in the absence of an occupational exposure). A worker is not entitled to compensation where the pre-existing condition is triggered or aggravated by substances which are present in both occupational and non-occupational settings unless the workplace exposure can be shown to have been of causative significance in aggravation of the condition. A speculative possibility that a workplace exposure to such a substance has caused an aggravation of the pre-existing contact dermatitis is not enough for the acceptance of a claim.

3. Temporary Disability

Wage-loss benefits are payable while the disability is a temporary one, but cease when the worker’s acute symptoms resolve or stabilize, or the worker reaches retirement age as determined by the Board.

4. Permanent Disability

(i) Work-Caused Contact Dermatitis

If workplace exposures have caused the worker to develop contact dermatitis (either allergic or irritant-induced) and the worker's acute symptoms do not entirely resolve so that the worker is left with a permanent impairment of the skin, the Board may assess permanent disability benefits under section 195 after considering the contact dermatitis table in the *Permanent Disability Evaluation Schedule* (see Appendix 3).

(ii) Permanent Aggravation of Pre-Existing Dermatitis

If workplace exposures have caused a permanent aggravation of the worker's pre-existing dermatitis condition, so that the worker is unlikely to return to the worker's pre-exposure state, the Board may assess permanent disability benefits under section 195 after considering the contact dermatitis table in the *Permanent Disability Evaluation Schedule* (see Appendix 3). In these cases, the Board considers whether proportionate entitlement under section 146 of the *Act* is appropriate. (See Item C6-44.00.)

In the situation described above, no permanent disability benefits are paid to a worker with a pre-existing condition when the worker has returned to the worker's pre-exposure state.

(iii) Contact Dermatitis due to Sensitization

If workplace exposures to a sensitizing agent have caused the worker to develop allergic contact dermatitis and the worker's acute symptoms resolve following removal from the workplace, the Board may consider the worker to have a permanent impairment if:

- the worker is left with a significant underlying allergy or sensitivity; and as a result
- the worker must avoid workplaces containing the sensitizing agent.

A significant underlying allergy or sensitivity is one where the worker reacts with recurrent signs and symptoms of marked extent and severity when exposed to a workplace sensitizing agent. The worker experiences these signs and symptoms when the worker returns to the workplace under conditions that do not expose the worker to excessive (i.e. irritant) levels of the sensitizing agent or other known dermal irritants.

In determining whether there is a need to avoid certain workplaces, the Board considers the medical evidence, including the nature of the sensitization and the

likelihood of a dermatological reaction should the worker return to a work environment containing the sensitizing agent. In making this assessment, the Board considers medical advice from the attending physician and/or Board Medical Advisor.

Where it is found that the worker has a permanent impairment due to a significant underlying allergy or sensitivity, the Board considers the contact dermatitis table found in the *Permanent Disability Evaluation Schedule* to assess the disability rating (see Appendix 3).

B. HEART CONDITIONS

Heart-related conditions which arise out of and in the course of a worker's employment and which are attributed to a specific event or cause or to a series of specific events or causes are generally treated as personal injuries. They are therefore adjudicated in accordance with the policies set out in Chapter 3. If the heart-related condition of a worker is one involving a gradual onset and is not attributed to a specific event or cause or to a series of events or causes, the claim will be adjudicated under section 136 of the *Act*. (See Item C3-16.00).

C. PSYCHOLOGICAL/EMOTIONAL CONDITIONS

The Board does accept claims where the psychological condition is a consequence of a compensable personal injury or occupational disease. (See Items C3-12.00, C3-22.30, and C3-22.40). However, the Board has not recognized any psychological or emotional conditions as occupational diseases related to employment.

i. Alcoholism

Alcoholism and alcohol-related cirrhosis of the liver have not been recognized by the Board as occupational diseases.

Research indicates that many factors may be operative in causing alcoholism. While employment is one of the suggested factors, the evidence does not clearly support a conclusion that employment does have causative significance or that, if it does, it has particular significance over and above the others. It appears rather as just one factor, along with the worker's individual physiology and psychology, their family, social and cultural surroundings and a chronic, progressive pattern of compulsive consumption.

D. FEDERAL GOVERNMENT EMPLOYEES

i. General

The rights of employees of the Federal Government to compensation for occupational disease are set out in section 4 of the *Government Employees Compensation Act.* This provides that an employee who . . . is disabled by reason of an industrial disease due to

the nature of the employment; and . . . the dependants of an employee whose death results from such . . . industrial disease . . . are, notwithstanding the nature or class of such employment, entitled to receive compensation at the same rate and under the same conditions as are provided under the law of the province where the employee is usually employed.

The meaning of "employee" is discussed in Item C2-5.00. The place where an employee is usually employed is discussed in Item C3-12.10.

ii. Meaning of "Industrial Disease" under Government Employees Compensation Act

"Industrial Disease" is defined in section 2 of the *Government Employees Compensation Act* to mean "any disease in respect of which compensation is payable under the law of the province where the employee is usually employed respecting compensation for workmen and the dependants of deceased workmen".

The *Government Employees Compensation Regulations* created under section 8(1)(a) of that act provides that any employee who is disabled by reason of a disease that is not an occupational disease but is due to the nature of the employment and peculiar to or characteristic of the particular process, trade or occupation in which the employee is employed at the time the disease was contracted and the dependants of a deceased employee whose death is caused by reason of such a disease, are entitled to receive compensation at the same rate as they would be entitled to receive under the *Government Employees Compensation Act* if the disease were an occupational disease, and the right to and the amount of such compensation is determined by the same board, officers or authorities and in the same manner as if the disease were an occupational disease.

EFFECTIVE DATE: July 14, 2025
AUTHORITY: Section 136 of the *Act.*
CROSS REFERENCES:
Item C2-5.00, *Admission of Workers, Employers, and Independent Operators*;
Item C3-12.00, *Personal Injury*;
Item C3-12.10, *Entitlement for Federal Government Employees*;
Item C3-16.00, *Pre-Existing Conditions or Diseases*;
Item C3-22.00, *Compensable Consequences*;
Item C3-22.30, *Compensable Consequences – Psychological Impairment*;
Item C3-22.40, *Compensable Consequences – Certain Diseases and Conditions*;
Item C6-44.00, *Proportionate Entitlement*;
Appendix 2, Schedule 1;

Appendix 3, *Permanent Disability Evaluation Schedule*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:

December 1, 2025 – Housekeeping change to update internal cross-reference, consequential to reformatting and renumbering Chapter 2, *Workers and Employers Covered by the Act*.
July 14, 2025 – Amendments to ensure consistency for pre-existing diseases as between personal injury and occupational disease claims.
December 1, 2022 – Policy changes made to Section C to replace outdated terminology.
January 1, 2021 – Policy changes made consequential to implementing the permanent partial disability benefits provisions of the *Workers Compensation Amendment Act, 2020* (Bill 23).
April 6, 2020 – This policy resulted from the consolidation of former policy items #30.50, #30.70, #32.00, #32.10, #32.15, and #32.85. The principles set out in Section C. i. were derived from *Workers Compensation Reporter* series Decision No. 348 (1982), 5 W.C.R. 127.
February 1, 2020 – Former policy item #30.50 was amended to provide guidance on legal issues of evidence and causation.
May 29, 2014 – Former policy item #30.70 was consequentially amended as a result of *Miscellaneous Statutes Amendment Act, 2014* (Bill 17 of 2014).
January 1, 2007 – Former policy item #30.50 was revised, including to provide that a worker may be considered to have a permanent impairment where the worker is left with a significant underlying allergy or sensitivity and as a result the worker must avoid workplaces containing the sensitizing agent.
July 16, 2002 – Housekeeping change was made to former policy item #30.50.

APPLICATION:

Applies to all decisions, including appellate decisions, made on or after July 14, 2025.

RE:	Introduction to Compensation For Temporary Disability	ITEM:	C5-33.00

BACKGROUND

1. Explanatory Notes

This policy sets out all the general rules for how the Board pays wage-loss benefits to workers under Division 6 of Part 4 of the *Act* – *Compensation for Worker Disability*, applicable to both temporary total disability and temporary partial disability.

2. The Act

Section 134(4):

> If an injury disables a worker from earning full wages at the work at which the worker was employed, compensation other than a health care benefit is payable under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] from the first working day following the day of the injury.

Section 135(1), in part:

> … a worker is entitled to compensation for a mental disorder, payable as if the mental disorder were a personal injury arising out of and in the course of a worker's employment…

Section 136(1), in part:

> Compensation is payable under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment…

Section 190:

> Compensation under this Division [Division 6 of Part 4 of the *Act* – Compensation for Worker Disability] is subject to the following provisions:
>
> (a) section 230 *[manner of compensation payment: periodic or lump sum]*;
>
> (b) section 231 *[payment of compensation in specific circumstances]*;
>
> (c) section 232 *[Board authority to discontinue or suspend payments]*;

(d) section 233 *[deduction in relation to payments from employer]*.

Section 191:

(1) Subject to subsection (2), if a temporary total disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the worker's average net earnings.

(2) Compensation to be paid under this section

(a) must not be less than an amount that equals $512.52 per week if the worker's average earnings per week are greater than or equal to that amount, and

(b) must be an amount that equals the worker's average earnings if the worker's average earnings per week are less than the amount referred to in paragraph (a).

Section 192:

(1) Subject to subsection (2), if a temporary partial disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the difference between

(a) the worker's average net earnings before the injury, and

(b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:

(i) the average net earnings that the worker is earning after the injury;

(ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury.

(2) The minimum compensation to be paid under this section must be calculated in accordance with section 191(2) but to the extent only of the partial disability.

Section 193, in part:

(1) This section applies if there is a recurrence of temporary total disability or temporary partial disability of a worker after a lapse of 3 years following the occurrence of the injury to the worker.

(2) For the purpose of determining the amount of compensation payable to the worker, the Board may calculate the compensation as if the date of the recurrence was the date of the injury if the Board considers that, by doing so, the compensation payable would more closely represent the percentage of actual loss of earnings of the worker by reason of the recurrence of the injury.

…

Section 233 (1):

In setting the amount of a periodic payment of compensation to a worker, the Board must consider payments, allowances or benefits that the worker may receive from the worker's employer during the period of the worker's disability, including a pension, gratuity or other allowance provided wholly at the expense of the employer.

POLICY

1. GENERAL

The Board makes decisions on:

- the worker's entitlement to wage-loss benefits;
- the amount of the wage-loss benefit payments; and
- the duration of the wage-loss benefit payments.

Wage-loss benefits are payable if an injury, mental disorder, or occupational disease resulting from a worker's employment causes a period of temporary disability from work.

As a general rule, the Board's decisions on wage-loss benefits relate to the past, the present, and continuing situations. The Board does not generally make a decision to terminate wage-loss benefits at a future date. The Board follows the procedures and rules of evidence set out by policy in Chapter 12 to make these decisions.

All compensation under Division 6 of Part 4 of the *Act* – Compensation for Worker Disability – is subject to the manner of compensation payments provision (section 230), the payment of compensation in specific circumstances provision (section 231), the Board's authority to discontinue or suspend payments (section 232), and deductions in relation to payments from the employer (section 233).

2. PHYSICAL OR PSYCHOLOGICAL IMPAIRMENT

Every claim has a physical, or psychological impairment as the result of a work-related injury, mental disorder, or occupational disease. It is the instigating factor without which the system never comes into play. The Board considers the medical evidence to determine whether a worker has experienced a physical or psychological impairment, and then determines the extent of compensation payable, i.e. whether the impairment is disabling. There are, therefore, two considerations on every claim. Firstly, the impairment itself, and secondly, the entitlement to benefits arising from the impairment.

The words “temporary”, “permanent”, “partial”, and “total” found in sections 191, 192, 194, 195, and 196 are applicable only to the impairment component of the claim and are not to be related to its compensable effects. To differentiate between the “temporary” and “permanent” consequences of an impairment is possible only by reference to the impairment itself. Once it has been determined that a worker has a temporary or permanent, partial or total physical or psychological impairment, the Board pays wage-loss benefits or permanent disability benefits to compensate for the disabling effects of that impairment in accordance with the requirements of the appropriate section of the *Act*.

3. TEMPORARY OR PERMANENT

In order to be eligible for wage-loss benefits, a worker must have a physical or psychological impairment that temporarily disables the worker from earning full wages at the work at which the worker was employed.

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

At the beginning of a claim, and throughout the period of “temporary” impairment, the Board considers the medical evidence to assess the degree of impairment, and whether the worker’s condition has stabilized as permanent.

4. DISABLED FROM EARNING FULL WAGES

Most compensable physical or psychological impairments involve an initial period during which the worker is temporarily disabled from earning full wages at the work at which the worker was employed, and the Board therefore pays wage-loss benefits. The impairment will usually improve in time until the temporary disability resolves, or the disabling effects of the impairment become permanent. However, in the case of some

diseases, there is no initial period of temporary disability; the condition is permanent right from the beginning and no wage-loss benefits are payable.

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

Even if a worker is found to have a temporary physical or psychological impairment, the Board does not pay wage-loss benefits unless that impairment causes the cessation of regular employment:

- If the impairment causes a full cessation from work, the Board pays wage-loss benefits calculated under section 191. (See policy in Item C5-33.10.)
- If the impairment causes only a partial cessation from work, or the worker returns to work in some capacity, or is capable of returning to work in some capacity, the Board calculates wage-loss benefits calculated under section 192. (See policy in Item C5-33.20) In determining whether the worker is capable of returning to work in some capacity, the Board applies the principles set out in the policy of Item C5-35.10.

5. COMPENSATION PAYABLE FROM THE FIRST WORKING DAY FOLLOWING THE DAY OF THE INJURY

Section 134(4) provides that wage-loss benefits are payable from the first working day following the day of the injury, for an injury, mental disorder, or occupational disease that disables a worker from earning full wages at the work at which the worker was employed.

5.1 Shift Work and First Working Day Following the Day of the Injury

If a worker is injured during a shift spanning two calendar days (i.e. beginning before midnight and ending after), the Board does not pay wage-loss benefits for any portion of that shift. On the other hand, a worker's entitlement to payment of wage-loss benefits will commence effective the next shift following the shift on which the worker is injured, even if that shift falls on the same calendar day as the end of the shift that is the day of the injury.

5.2 Working Beyond the Day of the Injury

If a worker continues to work beyond the day of the injury, wage-loss benefits become payable on the day the worker is actually disabled from earning full wages.

The Board takes into account the worker's partial earnings of the day on which the disability occurs to calculate the wage-loss benefits for the day of disability as follows:

A. if the worker works or is paid for one quarter of the day or less, wage-loss benefits are paid for the full day;

B. if the worker works or is paid for more than one quarter but less than three quarters of the day, wage-loss benefits are paid for half the day;

C. if the worker works or is paid for three quarters of the day or more, wage-loss benefits are not paid for the day.

Except where section 233(2) [Deduction in relation to payments from employer] is being applied, the employer is not refunded any money paid to the worker for time not worked on the day the worker is disabled from work.

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

5.3 Strike or Other Reason to Not Have Work

The first day the worker is disabled from earning full wages may fall on a day where the work at which the worker is employed is not available.

If the physical or psychological impairment disables the worker from earning full wages beyond the day of the injury and this results in an actual loss of earnings or a potential loss of earnings, the Board considers the requirement of section 134(4) is met and the Board pays wage-loss benefits.

If the physical or psychological impairment does not disable the worker from earning full wages beyond the day of the injury, meaning it does not result in any actual or potential loss of earnings, the Board does not consider the requirement of section 134(4) to be met and the Board does not pay wage-loss benefits.

In interpreting "potential loss" no rigid rules can be established since every case will have to be determined on the evidence received.

In cases where the work at which the worker is employed would not have been available such as where there is a lay-off due to lack of work, the Board generally considers the worker to be experiencing a potential loss of earnings, and pays wage-loss benefits. In those situations, the Board generally expects that the worker, if not physically or psychologically impaired by the compensable injury, mental disorder, or occupational disease, would have immediately sought new employment, and the Board should not speculate as to if and when it would have been found.

In cases where the work at which the worker is employed on the day of the injury would not have been available afterward, such as where the worker has no other attachment to the labour force than a single day's work at a polling station during an election, the Board may conclude that there was no actual or potential loss of earnings, and not pay wage-loss benefits. If the evidence shows that the person would not normally be available on the general labour market beyond the day of work on which the person was injured, the Board considers the evidence to rebut the general expectation that a person would have immediately sought new employment, if not for the impairment resulting from the compensable injury, mental disorder, or occupational disease.

The Board would not normally expect a worker to seek other work in situations such as strikes, a statutory holiday, weekends or normal days off, vacations or absences required for medical treatment unrelated to the work injury. The Board does not normally consider those days to be a first working day following the day of the injury in which the worker could be experiencing an actual or potential loss of earnings. If there is evidence that the worker would have undertaken other work but the impairment resulting from the compensable injury, mental disorder, or occupational disease prevented it, the Board may reach the opposite conclusion.

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

6. EARNINGS USED FOR WAGE-LOSS BENEFITS

The Board uses a worker's average net earnings to calculate the amounts (under both section 191 and 192) of wage-loss benefits it will pay to a worker for temporary disability compensation. In any of these calculations, if prior to the compensable injury, mental disorder, or occupational disease, the worker was engaged in multiple employments, the Board combines the earnings of all employments to calculate, as applicable, the worker's:

- pre-injury earnings;
- pre-injury average net earnings;
- actual post-injury average net earnings; and
- estimated post-injury earnings.

This applies regardless of whether the compensable physical or psychological impairment only disables the worker from one occupation. This applies whether or not the other employments are covered by the compensation provisions of the *Act* or are self-employment. The combined totals are subject to the statutory maximum.

If prior to the compensable injury, mental disorder, or occupational disease, the worker is also the principal of the company that is the employer, the Board's obligations extend only to the losses incurred in the worker's capacity as an employee. Wage-loss benefits cannot be paid to reflect any detrimental effect that the injury may have on the company's business.

7. POSSIBLE DEDUCTIONS FROM WAGE-LOSS BENEFITS

If an employer continues to pay a worker salary, allowances, or benefits while the worker is receiving wage-loss benefits, under section 233(1) the Board may deduct these amounts from the compensation that is otherwise payable to the worker.

If an employer terminates the service of a worker after the worker sustains a compensable injury, mental disorder, or occupational disease, and the employer pays the worker a termination of employment payment required by law (legislative requirement or contractual agreement), the Board does not deduct this amount from the compensation that is otherwise payable to the worker. This is because an uninjured worker would have been free to take any other job that the worker could find, receive full wages in respect of that job, and still be entitled to the termination pay. By the law of British Columbia, the worker is entitled to be paid twice for the period covered by the termination pay. Termination pay is intended to allow for the worker to be in that position.

EFFECTIVE DATE:	January 1, 2024
AUTHORITY:	Section 190, 191, 192, and 193 of the *Act*.
CROSS REFERENCES:	Item C5-33.10, *Wage-Loss Benefits For Temporary Total Disability*; Item C5-33.20, *Wage-Loss Benefits For Temporary Partial Disability*; Item C5-34.00, *Duration of Wage-Loss Benefits* (Section 4.3 If the Worker's Temporary Disability Stabilizes as Permanent); Item C5-34.10, *Payment of Wage-Loss Benefits*; Item C5-35.10, *Duty to Cooperate*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	This policy consolidates former policy items #33.00, #34.10, #34.30, #34.31, #34.32, #34.42, and #35.22, and includes concepts from former policy item #34.40, of the *Rehabilitation Services & Claims Manual*, Volume II, consequential to reformatting and renumbering the policies in Chapter 5. Former policy item #34.42 incorporated portions of *Workers' Compensation Reporter* Decision No. 107, [1975] 2 W.C.R. 42.
APPLICATION:	Applies to all decisions made on or after January 1, 2024.

RE: Wage-Loss Benefits For Temporary Total Disability **ITEM: C5-33.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on a worker's entitlement to "temporary total" disability compensation.

2. The Act

Section 134(4):

> If an injury disables a worker from earning full wages at the work at which the worker was employed, compensation other than a health care benefit is payable under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] from the first working day following the day of the injury.

Section 135(1), in part:

> … a worker is entitled to compensation for a mental disorder, payable as if the mental disorder were a personal injury arising out of and in the course of a worker's employment…

Section 136(1), in part:

> Compensation is payable under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment…

Section 154(1):

> The Board may require a worker who applies for or is receiving compensation under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] to be medically examined at a place reasonably convenient for the worker.

Section 190:

Compensation under this Division [Division 6 of Part 4 of the *Act* – Compensation for Worker Disability] is subject to the following provisions:

(a) section 230 *[manner of compensation payment: periodic or lump sum]*;

(b) section 231 *[payment of compensation in specific circumstances]*;

(c) section 232 *[Board authority to discontinue or suspend payments]*;

(d) section 233 *[deduction in relation to payments from employer]*.

Section 191:

(1) Subject to subsection (2), if a temporary total disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the worker's average net earnings.

(2) Compensation to be paid under this section

(a) must not be less than an amount that equals $512.52 per week if the worker's average earnings per week are greater than or equal to that amount, and

(b) must be an amount that equals the worker's average earnings if the worker's average earnings per week are less than the amount referred to in paragraph (a).

Section 193, in part:

(1) This section applies if there is a recurrence of temporary total disability or temporary partial disability of a worker after a lapse of 3 years following the occurrence of the injury to the worker.

(2) For the purpose of determining the amount of compensation payable to the worker, the Board may calculate the compensation as if the date of the recurrence was the date of the injury if the Board considers that, by doing so, the compensation payable would more closely represent the percentage of actual loss of earnings of the worker by reason of the recurrence of the injury.

…

Section 233:

(1) In setting the amount of a periodic payment of compensation to a worker, the Board must consider payments, allowances or benefits that the worker may receive from the worker's employer during the period of the worker's disability, including a pension, gratuity or other allowance provided wholly at the expense of the employer.

(2) An amount deducted under this section from the compensation otherwise payable to a worker may be paid to the worker's employer out of the accident fund.

POLICY

1. GENERAL

Compensable injuries, mental disorders, and occupational diseases can involve an initial period of temporary total disability, during which the worker is disabled from earning any wages, and therefore full wage-loss benefits are paid. The resulting physical or psychological impairment, and correspondingly, the disability, will usually improve in time, generally passing through a period where the worker is entitled to temporary partial disability wage-loss benefits, until the disability resolves or becomes permanent.

2. AMOUNT OF COMPENSATION FOR TEMPORARY TOTAL DISABILITY

If a temporary total disability results from a worker's injury, mental disorder, or occupational disease, section 191(1) provides that the wage-loss benefits consist of periodic payments to the injured worker of an amount equal to 90% of the worker's average net earnings.

The *Act* sets the minimum amount the Board considers when paying wage-loss benefits to a worker entitled to temporary total disability compensation, which is adjusted each year as follows:

			$ Per Week
January 1, 2025	—	December 31, 2025	501.67
January 1, 2026	—	December 31, 2026	512.52

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

If the worker's pre-injury average earnings per week are less than the minimum amount set out by the *Act* for the year of injury, the Board uses the worker's pre-injury average

earnings as the worker's pre-injury average net earnings to calculate the worker's wage-loss benefits. The Board may, as a result, pay the worker less than the minimum set out by the *Act*.

If the worker's pre-injury average earnings per week are greater than or equal to the minimum amount set out by the *Act* for the year of injury, the Board uses the worker's pre-injury average earnings to calculate the worker's pre-injury average net earnings under policies in Chapter 9, and does not pay the worker less than the minimum amount set out by the *Act*.

The minimum is subject to cost-of-living adjustments as described in Item C7-51.00. However, these adjustments only apply to injuries or disablements occurring after the adjustments come into force. Existing payments are not automatically increased to a new minimum, although they may be the subject of cost-of-living adjustments in their own right.

3. FROM TEMPORARY TOTAL DISABILITY TO TEMPORARY PARTIAL DISABILITY

The Board uses the best evidence available to make its decision as to whether a temporary total disability has resolved to a point of recovery where the Board considers the worker's disability to be only a temporary "partial" disability. It may be appropriate for the Board to rely solely upon reports of the worker's physician, qualified practitioner, and/or other recognized health care professional, or the Board may seek medical advice on the contents of such reports and/or contact the health care provider for further discussion.

In some cases, it may be necessary for the Board to have the worker medically examined in order for the Board to decide whether the temporary total disability has resolved to a point of being only a temporary partial disability.

Claims are then referred promptly for that purpose and the examination is to be given priority.

Whether through reports provided by a worker's physician, qualified practitioner, and/or other recognized health care professional, or reports resulting from a Board-ordered medical examination, the Board considers the medical evidence to determine whether the worker:

A. is still totally disabled;

B. is fully recovered;

C. is temporarily partially disabled;

D. has a residual permanent disability which shows no reasonable likelihood of change.

If the Board determines that the worker is temporarily partially disabled, the Board uses the medical evidence to:

A. estimate the period required for full recovery or stability;

B. estimate a recommendation for a future examination;

C. establish any medical restrictions to re-employment, with the reason for such restrictions;

D. identify any medical or other factors found in the evidence that the Board considers significant in the determination of the worker's recovery process.

If the Board uses the medical evidence to determine the worker is temporarily partially disabled rather than temporarily totally disabled, but the worker is not able to return to work in some capacity (i.e. suitable work), the Board may refer the worker for vocational rehabilitation assistance or a comprehensive employability assessment.

The Board advises the worker and the employer that the worker is considered to be partially disabled and that further wage-loss benefits will be determined using the policy in Item C5-33.20.

EFFECTIVE DATE:	January 1, 2024
AUTHORITY:	Section 191 of the *Act*.
CROSS REFERENCES:	Item C5-33.20, *Wage-Loss Benefits For Temporary Partial Disability*; Item C7-51.00, *Cost of Living Adjustments to Periodic Payments*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – Housekeeping change to update internal cross-reference, consequential to reformatting and renumbering Chapter 7, *Protection of and Deductions from Benefits*. June 17, 2024 – Housekeeping amendment. This policy consolidates former policy items #34.00, #34.20, and #35.11 of the *Rehabilitation Services & Claims Manual*, Volume II, consequential to reformatting and renumbering the policies in Chapter 5. Former policy item #35.11 had references to Board officers, Board Medical Advisors, and Vocational Rehabilitation Services deleted on June 1, 2009; and amendments to clarify that a Board officer could make a referral to Vocational Rehabilitation Services to assist with arranging a return to work, on November 1, 2002.
APPLICATION:	Applies to all decisions made on or after January 1, 2024.

RE: Wage-Loss Benefits For Temporary Partial Disability **ITEM: C5-33.20**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on a worker's entitlement to "temporary partial" disability compensation.

2. The Act

Section 134(4):

> If an injury disables a worker from earning full wages at the work at which the worker was employed, compensation other than a health care benefit is payable under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] from the first working day following the day of the injury.

Section 135(1), in part:

> … a worker is entitled to compensation for a mental disorder, payable as if the mental disorder were a personal injury arising out of and in the course of a worker's employment…

Section 136(1), in part:

> Compensation is payable under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment…

Section 190:

> Compensation under this Division [Division 6 of Part 4 of the *Act* – Compensation for Worker Disability] is subject to the following provisions:
>
> (a) section 230 *[manner of compensation payment: periodic or lump sum]*;
>
> (b) section 231 *[payment of compensation in specific circumstances]*;
>
> (c) section 232 *[Board authority to discontinue or suspend payments]*;

(d) section 233 *[deduction in relation to payments from employer]*.

Section 191(2):

Compensation to be paid under this section

(a) must not be less than an amount that equals $512.52 per week if the worker's average earnings per week are greater than or equal to that amount, and

(b) must be an amount that equals the worker's average earnings if the worker's average earnings per week are less than the amount referred to in paragraph (a).

Section 192:

(1) Subject to subsection (2), if a temporary partial disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the difference between

(a) the worker's average net earnings before the injury, and

(b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:

(i) the average net earnings that the worker is earning after the injury;

(ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury.

(2) The minimum compensation to be paid under this section must be calculated in accordance with section 191(2) but to the extent only of the partial disability.

POLICY

1. GENERAL

If a worker's physical or psychological impairment from a compensable injury, mental disorder, or occupational disease causes only a partial cessation from work, or the worker returns to work in some capacity, or the worker is capable of returning to work in some capacity, the Board pays wage-loss benefits calculated under section 192.

Wage-loss benefits paid under section 192 are based on the worker's post-injury earning capacity during the worker's period of temporary partial disability.

2. MEANING OF TEMPORARY PARTIAL DISABILITY

The meaning of "temporary partial" is governed by the principles set out in Section 2 of the policy in Item C5-33.00. The words "temporary" and "partial" in section 192 are applicable only to the impairment component of the claim and are not related to its compensable effect. In order to be eligible for wage-loss benefits under section 192(1), a worker must have a temporary partial physical or psychological impairment as a result of a work-related injury, mental disorder, or occupational disease, which is disabling the worker from earning full wages. To determine if an injury, mental disorder, or occupational disease has totally or partially disabled the worker, the Board considers how the physical or psychological impairment impacts the worker's ability to earn full wages at the work at which the worker was employed on the day of the injury.

The Board considers the worker to be temporarily partially disabled if a worker continues to carry out, or is capable of carrying out, the worker's pre-injury work in part or with accommodation, or performs some other suitable work.

If a partially disabled worker in a suitable work arrangement is subsequently laid off due to lack of work, the Board generally considers the worker to be experiencing a potential loss, and pays wage-loss benefits for the worker's temporary partial disability.

The Board generally continues to pay wage-loss benefits once it has started, even if the worker would not have been working for some period during that time, had the injury not occurred. Policy in Item C5-34.00 addresses the termination of wage-loss benefit payments and other circumstances that may affect entitlement.

2.1 Workers Engaged in Own Business

If a self-employed worker continues to work following a compensable injury, mental disorder, or occupational disease, in some capacity (perhaps performing lighter administrative or other suitable work), this means the worker is temporarily partially disabled, not temporarily totally disabled. The Board applies section 192 and pays only partial wage-loss benefits. Full wage-loss benefits will not be paid by the Board just because the worker cannot perform the heavier work.

If the worker is also the principal of the company that is the employer, the Board's obligations extend only to the losses incurred in the worker's capacity as an employee. Wage-loss benefits cannot be paid to reflect any detrimental effect that the injury may have on the company's business.

3. AMOUNT OF COMPENSATION FOR TEMPORARY PARTIAL DISABILITY

If a temporary partial disability results from a worker's injury, mental disorder, or occupational disease, section 192 provides that the wage-loss benefits consist of periodic payments to the injured worker of an amount equal to 90% of the difference between:

A. the worker's pre-injury average net earnings, and;

B. whichever of the following amounts the Board considers better represents the worker's loss of earnings:

(i) the average net earnings that the worker is actually earning after the injury; or

(ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation.

Section 192 wage-loss benefits represent a worker's post-injury wage loss over the short-term, and are based on the worker's post-injury earning capacity.

Post-injury earning capacity may be equal to the worker's actual earnings unless the Board determines that the worker is capable of earning more than what is actually being earned. In these cases, the wage-loss benefit is calculated by deducting what the worker is estimated to be capable of earning from the pre-injury earnings.

In determining temporary partial disability wage-loss benefit entitlement under section 192 for workers with Personal Coverage, the Board does not pay wage-loss benefits in excess of the amount of Personal Coverage purchased.

The Board must, in all cases, provide the worker with the reasons for paying wage-loss benefits under section 192 and more particularly, when only partial payments are made.

3.1 Minimum Amount of Compensation for Temporary Partial Disability

The minimum amount of wage-loss benefits for temporary partial disability is the amount set out in section 191(2) for temporary total disability, but only to the extent of the partial disability. (See policy in Section 2 of Item C5-33.10.)

3.2 The Worker's Pre-Injury Average Net Earnings

If the worker's pre-injury average earnings per week are greater than or equal to the amount per week set out in section 191(2)(a) for the year of injury (see policy in Section 2 of Item C5-33.10), the Board uses the worker's pre-injury average earnings to calculate the worker's pre-injury average net earnings under policy in Chapter 9.

If the worker's pre-injury average earnings per week are less than the amount per week set out in section 191(2)(a) for the year of injury (see policy in Section 2 of Item C5-33.10), the Board uses the worker's pre-injury average earnings as the worker's pre-injury average net earnings to make its determination under section 192(1).

3.3 Actual Post-Injury Average Net Earnings

In determining what better represents the worker's post-injury earning capacity, the Board considers whether the worker has returned to work in some capacity, and the worker's actual average net earnings, if any.

3.4 Estimated Post-Injury Average Net Earnings in a Suitable Occupation

In determining what better represents the worker's post-injury earning capacity, the Board considers whether the worker is able to return to work in some capacity and estimates the average net earnings the worker would be capable of earning in a suitable occupation.

When determining entitlement under section 192, the Board generally considers suitable work to be a suitable occupation. (See policy in Item C5-35.10.)

A suitable occupation is one that:

- does not endanger a worker's recovery, or impede the health and safety of the worker and/or others;
- the worker has the skills, competencies, qualifications, and functional abilities that the occupation requires;
- the worker is medically capable of performing; and
- is reasonably available over the short-term in the worker's community or, where appropriate, in British Columbia at large.

In estimating the average net earnings a worker is capable of earning in a suitable occupation, the Board may refer the worker for vocational rehabilitation assistance and/or a comprehensive employability assessment to assist with the estimation. (See policy in Item C11-89.00.)

3.5 Post-Injury Earnings for Workers Engaged in Own Business

If a self-employed worker continues to work in some capacity following a compensable injury, mental disorder, or occupational disease, the Board takes into consideration the remunerative work the worker is doing in the capacity of being self-employed, to calculate the worker's post-injury earnings.

If a worker was not engaged in the worker's own business prior to the compensable injury, mental disorder, or occupational disease, and the worker commences a business afterwards, the Board may estimate the value of the work the worker is doing, rather than simply consider the worker's reported earnings. This is because, being in control of the business, the worker determines what personal salary is paid. The worker may take no earnings, or very low earnings, out of the business when it is starting up. Yet, the worker may be doing a substantial amount of work that, under normal circumstances, would command a significant wage.

3.6 When to Use Estimated Earnings Instead of Actual Earnings

The Board bases a worker's wage-loss benefits on estimated earnings rather than on actual earnings in the following cases:

- The worker is employable but does not have a job;
- The worker has a job but is not maximizing earning capacity up to the pre-injury wage rate;
- The worker has, for personal reasons, withdrawn from the workforce;
- The worker fails to cooperate with the recovery and return-to-work process.

3.7 Change in the Amount to be Paid for the Worker's Temporary Partial Disability

The amount of wage-loss benefits the Board will pay under section 192 is subject to periodic review. The Board's review may include a vocational rehabilitation assessment regarding what the worker actually earned in the intervening period, if anything, and an estimate of what the worker could have earned in the opinion of the Board. The Board pays wage-loss benefits based on this information and on any other evidence the Board considers significant.

EFFECTIVE DATE:	January 1, 2024
AUTHORITY:	Section 192 of the *Act*.
CROSS REFERENCES:	Item C5-33.00, *Introduction to Compensation For Temporary Disability*; Item C5-33.10, *Wage-Loss Benefits For Temporary Total Disability*; Item C5-34.00, *Duration of Wage-Loss Benefits*; Item C5-35.10, *Duty to Cooperate*; Item C11-89.00, *Vocational Rehabilitation – Employability Assessments – Temporary Partial Disability and Permanent Partial Disability*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	March 2, 2026 – Housekeeping change to update the terms "Personal Optional Protection" and "POP" to "Personal Coverage." This policy consolidates former policy items #35.00, #35.10, #35.20, #35.21, #35.23, and #35.24, and includes concepts from former policy items #34.10 and #34.32, of the *Rehabilitation Services & Claims*

Manual, Volume II, consequential to reformatting and renumbering the policies in Chapter 5.
Former policy item #35.20 had references to Board officers, Compensation Services, and Vocational Rehabilitation Services deleted on June 1, 2009; and amendments to clarify that compensation paid under then section 30 represent a worker's post-injury wage-loss over the short term and is based on the worker's post-injury earning capacity, on November 1, 2002.

APPLICATION: Applies to all decisions made on or after January 1, 2024.

RE: Duration of Wage-Loss Benefits **ITEM: C5-34.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the factors and variables that affect how long a worker may receive wage-loss benefits from the Board for a temporary disability, or how the amount of wage-loss benefits may change.

2. The Act

Section 6, in part:

(1) This section applies if the minister responsible for the *School Act* or the minister responsible for the *College and Institute Act*, as applicable, and the minister responsible for the administration of this Act approve

(a) a vocational or training program, and

(b) a school or other location as a place at which the vocational or training program is to be provided.

…

(3) In relation to a person who is deemed to be a worker under subsection (2), compensation under this Act is payable under the compensation provisions for injuries to the worker arising out of and in the course of training for that worker.

(4) As limits on subsection (3), if an injury results in a period of temporary disability with no loss of earnings,

(a) subject to paragraph (b) of this subsection, a health care benefit only is payable, and

(b) if training allowances paid by Canada or British Columbia are suspended, the Board may, for the period the Board considers advisable, pay compensation in the amount of the training allowance.

…

Section 125:

(1) The Board may at any time, on its own initiative or on application, reopen a matter that had been previously decided under a compensation provision by the Board or an officer or employee of the Board if, since the decision was made in the matter,

(a) there has been a recurrence of a worker's injury, or

(b) there has been a significant change in a worker's medical condition that the Board had previously decided was compensable.

(2) If the Board determines that the circumstances described in subsection (1) justify a change in a previous decision respecting compensation or rehabilitation, the Board may make a new decision that varies the previous decision or order.

Section 153:

(1) A worker who applies for or is receiving compensation under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] must provide the Board with the information that the Board considers necessary to administer the worker's claim.

(2) If a worker fails to comply with subsection (1), the Board may reduce or suspend payments to the worker until the worker complies.

Section 154(3):

The Board may reduce or suspend compensation for a worker if the worker

(a) persists in unsanitary or injurious practices that tend to imperil or delay the worker's recovery, or

(b) refuses to submit to medical or surgical treatment that the Board considers, based on expert medical or surgical advice, reasonably essential to promote the worker's recovery.

Section 154.2(6):

If a worker fails to comply with subsection (2) [a worker's duty to cooperate with an employer and the Board in the worker's early and safe return to, or continuation of work], the Board may reduce or suspend payments of compensation to the worker until the worker complies.

Section 201(2), in part:

> … the Board may not make a periodic payment to a worker under this Division [Division 6 of Part 4 of the *Act* – Compensation for Worker Disability] if the worker ceases to have the disability for which the periodic payment is to be made.

Section 232(1):

> If a worker is confined to prison, the Board may cancel, withhold or suspend the payment of compensation for the period the Board considers advisable.

POLICY

1. GENERAL

Section 201(2) provides that the Board may not pay compensation to a worker under Division 6 of Part 4 of the *Act* – Compensation for Worker Disability − (temporary, permanent, recurrence, non-traumatic hearing loss, disfigurement, and retirement benefit contribution), if the worker ceases to have the disability for which the periodic payment is to be made.

The nature of a temporary disability may also change, affecting a worker's entitlement under the *Act*.

If the condition for which the worker is receiving temporary disability compensation becomes permanent, the worker is entitled to be assessed for permanent disability benefits. This entitlement is dealt with in Chapter 6.

2. CHANGE IN THE NATURE OF THE WORKER'S TEMPORARY DISABILITY

A worker's entitlement to wage-loss benefits for a temporary disability resulting from a work-related injury, mental disorder, or occupational disease disablement may change in either of the following circumstances.

When the worker's physical or psychological impairment resolves to the point where the Board no longer considers the worker temporarily totally disabled, the worker may be entitled to temporary partial disability wage-loss benefits under section 192. This entitlement is addressed by policy in Item C5-33.20.

If the worker's physical or psychological impairment worsens to the point where the Board considers the worker's temporary partial disability has become temporary totally disabling, the worker may be entitled to temporary total disability wage-loss benefits under section 191. This entitlement is addressed by policy in Item C5-33.10.

3. FACTORS THAT MAY AFFECT ENTITLEMENTS

In general, a worker's entitlement to wage-loss benefits continues once it has started and the worker's temporary disability continues. However, the Board may exercise its authority to reduce or suspend wage-loss benefits under other provisions of the *Act*, in certain circumstances.

3.1 Vacation and Travel

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

If a worker in receipt of wage-loss benefits wishes to travel to another place as part of a vacation or for other reasons, the worker should notify the Board. In general, the Board has no objection to wage-loss benefits being continued while a worker is travelling on vacation. However, if the vacation may hinder or protract recovery because of delayed treatment or the activities planned, the Board may reduce or suspend the worker's compensation if it exercises its discretion under section 154(3)(a) and makes a decision using policy in Item C10-74.00. The Board considers the following:

A. If there is to be a period with no treatment which may protract recovery, the Board advises the worker not to discontinue treatment and that if the worker discontinues treatment, it may affect the worker's entitlement to wage-loss benefits. The Board seeks medical advice before reducing or suspending wage-loss benefits compensation.

B. If the Board considers the activities planned for the vacation may suggest that the worker is not disabled or may protract recovery, the Board advises the worker that participation may affect the worker's entitlement to wage-loss benefits. The Board seeks medical advice before reducing or suspending wage-loss benefits compensation.

3.2 Personal Circumstances

In general, the Board continues to pay wage-loss benefits if a worker temporarily suspends treatment for a compensable injury during a period of temporary disability because of personal reasons, such as a family emergency.

However, the Board uses the policy in Item C10-74.00 to reduce or suspend the worker's compensation for failing to submit to medical or surgical treatment that the Board considers reasonably essential to promote the worker's recovery.

3.3 Strike or Lay-Off

The Board continues to pay wage-loss benefits to a worker whose temporary disability continues, even in the event of a strike or lay-off at the place of the worker's injury employer, which would have meant that the worker would not be working.

3.4 Practical Delays in Returning to Work

When a worker's temporary disability resolves or stabilizes as permanent, the worker may be slightly delayed in returning to a distant place of work, or from a treatment centre back to the worker's home community. The delay could be due to such things as traveling requirements, or requiring a few days for the worker to be medically cleared to return to work. In these limited cases, the Board may extend full wage-loss benefits for a few days beyond the time when the disability ceases. The Board does not provide this type of extension if it concludes the worker is unnecessarily delaying the return to work.

3.5 Education or Training Programs

If a worker who has been receiving wage-loss benefits for temporary total or partial disability commences an educational or training program, the question arises as to the continuation of payments by the Board during the course of the program.

The fact that a worker undertakes a course of training while receiving wage-loss benefits for temporary disability under section 191 or 192 does not impact the application of the policy in Item C11-88.50.

3.5.1 Education or Training Programs Arranged Before the Injury

Prior to injury, a worker may have arranged to undertake a retraining or educational course as part of career development or to become established in some new career. If the course involves time off work, the worker could be anticipating a period when there will be no earnings save for training allowances payable by the department continued under the *Department of Employment and Social Development Act* (Employment and Social Development Canada – "ESDC") or a similar agency. Since this training allowance will continue to be paid whether or not there is a compensable injury, the worker's financial position while taking the course is no worse because of the injury than if there had been no injury.

Therefore, the Board considers that a worker is not disabled as a result of the compensable injury and no wage-loss benefit is payable while undertaking a training or educational program arranged prior to the injury. Under the terms of some collective agreements, a worker continues to receive full wages while undertaking a training program. In such cases, an arrangement is normally made with ESDC for any training allowance to be paid to the employer. The Board would expect that an employer would continue to pay a worker's salary while taking the course, regardless of the fact that the

worker had previously incurred a compensable injury. In this case, there is no financial loss because of the injury while taking the course and no wage-loss benefit is payable. Nor is the employer refunded the continuation of salary paid to the worker during the course.

In some circumstances, ESDC will "top up" a training allowance to bring it up to the amount of a normal Employment Insurance payment. If the Board makes no payment of wage-loss benefits to a worker during a training course, it is understood that any entitlement of the worker to have the training allowances "topped up" by ESDC will be unaffected by the occurrence of the compensable injury. There is, therefore, no justification for the payment of wage-loss benefits during the course.

It is not necessary for all the details of the course as to time, place, subject matter, etc. to have been settled prior to the injury for it to be considered as "pre-arranged". For example, an apprentice may be required to spend some part of each year of the apprenticeship in school. While the exact dates may not be known at the date of injury, the worker must, at that time, clearly anticipate a period at school to be undergone in the near future. It is, therefore, reasonable to apply the rules set out above.

3.5.2 Education or Training Programs Arranged After the Injury

The Board generally continues to pay wage-loss benefits to a worker who decides to use the worker's recovery time to improve education or work skills by undertaking a retraining or educational program. If the worker is only taking the program at that particular time because of the physical or psychological impairment resulting from the work-related injury, mental disorder, or occupational disease, the Board continues to pay wage-loss benefits, even if the worker will also receive a training allowance from another government agency.

If the worker's condition improves to the point where the worker is able to return to work in some capacity, the Board may reduce the wage-loss benefits by the amount the Board estimates the worker is capable of earning in a suitable occupation.

3.6 Subsequent Non-Compensable Incidents

If a subsequent non-compensable incident occurs at a time when a worker is still recovering from a compensable injury, the following principles apply.

A subsequent non-compensable incident may include:

- sustaining a non-compensable injury, condition, disease, or disability; or
- undergoing surgery, tests or other treatment for a non-compensable injury, condition, disease, or disability.

In the event that a worker temporarily suspends treatment for a compensable injury, mental disorder, or occupational disease, because of personal reasons, such as a family emergency or a vacation, this would not be considered a subsequent non-compensable incident.

The Board is only authorized to pay for disability that is caused by an employment-related injury, mental disorder, or occupational disease, and only to the extent of that disability. For this reason, the Board does not pay for periods of disability caused by a subsequent non-compensable incident.

If a worker is still temporarily disabled by a compensable injury, mental disorder, or occupational disease, when a subsequent non-compensable incident occurs, the Board estimates when the worker would have reached maximum medical recovery. The Board then continues to pay wage-loss benefits for the period that the Board estimates the worker would have taken to reach maximum medical recovery from the compensable injury, mental disorder, or occupational disease, had the subsequent non-compensable incident not occurred.

When the estimated date for terminating wage-loss benefits arrives, if the worker is still disabled, the Board makes a new decision as to whether the disability, or increased disability, is due to the compensable injury, mental disorder, or occupational disease, or the subsequent non-compensable incident that has aggravated the compensable injury, mental disorder, or occupational disease. If the disability is due to the subsequent non-compensable incident, the Board terminates wage-loss benefits. However, if the disability is due to the compensable injury, mental disorder, or occupational disease, wage-loss benefits may be continued.

In the marginal cases, it is impossible to do better than weigh the evidence related to the compensable injury, mental disorder, or occupational disease, against the evidence related to the subsequent non-compensable incident to reach a conclusion on the termination of wage-loss benefits. For decisions respecting the compensation or rehabilitation of a worker, the standard of proof under section 339(3) of the *Act* is “at least as likely as not.”

The above applies even if the treatment for the subsequent non-compensable incident is carried out at the same time as treatment for the compensable injury, mental disorder, or occupational disease, and might not have been carried out at the time if the worker had not then sought treatment for the condition resulting from the compensable injury, mental disorder, or occupational disease.

4. TERMINATION OF WAGE-LOSS BENEFITS

The Board does not pay, or stops paying, wage-loss benefits when the worker ceases to have the temporary disability (i.e. the temporary disability resolves, or stabilizes as a

permanent impairment). The Board does not generally set a date for terminating wage-loss benefits into the future.

4.1 Estimated Date of Recovery or Stabilization

An estimated date of recovery from a health care provider is of assistance to the worker, the employer, and the Board to prepare a recovery plan. However, it is important to note that these estimates are based on the best available information at that time, and may change as the worker's claim progresses or as more information becomes available. It cannot therefore be regarded as the sole criterion for the payment of wage-loss benefits and is only one factor to be considered.

The Board does not pay wage-loss benefits to a worker with no temporary disability. If the worker is still temporarily disabled on the estimated date of recovery, the Board continues to pay wage-loss benefits for as long as a worker continues to be temporarily disabled by the physical or psychological impairment resulting from the work-related injury, mental disorder, or occupational disease until the worker has returned to work, or until the worker has attained the age at which compensation is terminated under section 201(1) of the *Act* (see policy in Item C5-34.20).

The worker has a responsibility to monitor the physical or psychological impairment for improvement, and a duty to cooperate in the timely and safe return to work before the estimated date of recovery if the worker becomes fit to return to work.

4.2 If the Worker's Temporary Disability Resolves

The Board stops paying temporary wage-loss benefits when the worker recovers from the work-related injury, mental disorder, or occupational disease.

This is so even if the worker remains off work or is unemployed:

- in order to prevent further occurrences of the condition (wage-loss benefits are not payable for preventative measures); or
- due to factors such as fire hazard, seasonal closure, strike, or lock-out.

4.3 If the Worker's Temporary Disability Stabilizes as Permanent

When a temporary disability stabilizes as permanent, the Board stops paying wage-loss benefits, and the worker is entitled to be assessed for permanent disability benefits under sections 194, 195, and 196.

In order to determine whether the worker's condition has stabilized as permanent to the extent that permanent disability benefits should be assessed, the Board first considers the medical evidence to assess the degree of the worker's impairment, and determines

whether the worker's condition has stabilized. The Board considers whether the medical evidence:

A. clearly indicates the condition has stabilized as permanent;

B. clearly indicates the condition has not yet stabilized as permanent;

C. does not yet clearly indicate whether or not the condition has stabilized as permanent, and

(i) there is a likelihood of minimal change; or

(ii) there is a likelihood of significant change.

The Board reviews the evidence to determine which category the worker's condition fits within as best as possible, and determines whether the condition is temporary or permanent on the merits of the case.

Having regard to the relevant medical evidence, the Board then decides whether the worker's condition is permanent to the extent that permanent disability benefits should be assessed.

In the case of (A), the Board considers the condition permanent; the permanent disability is assessed. The Board considers a condition to have plateaued or become stable where there is little potential for improvement or where any potential changes are in keeping with the normal fluctuations in the condition which can be expected with that kind of disability.

In the case of (B), the Board considers the condition is still temporary; the Board maintains the worker on wage-loss benefits under section 191 or 192.

In the case of (C)(i), the Board determines there is only a potential for minimal change, the Board usually considers the condition to be permanent; and assesses the permanent disability benefits immediately on the basis of the prognosis. This approach is particularly helpful where the disability is itself minor.

In the case of (C)(ii), the Board determines there is a potential for significant change in the condition, the Board applies the following guidelines:

A. If the potential change is likely to resolve relatively quickly (generally within 12 months), the Board considers the condition temporary and maintains the worker on wage-loss benefits under section 191 or section 192, and schedules a further medical examination.

B. If the potential change is likely to be protracted (generally over 12 months), the Board considers the condition permanent, and assesses

the permanent disability. The Board pays the permanent disability benefits immediately on the worker's present degree of disability, and schedules the claim for future review.

4.4 Worker's Age at the Date of the Injury

The *Act* limits the payment of temporary disability compensation to the worker reaching retirement age under section 201. This entitlement is addressed by the policy in Item C5-34.20.

4.5 If the Worker is Incurring No Loss of Earnings, Despite the Temporary Impairment

In all cases, the worker is no longer entitled to wage-loss benefits under section 191 and section 192 where, notwithstanding the existence of a temporary impairment, the worker is incurring no loss of earnings as a result of the injury.

5. CHANGES IN WORKER'S CONDITION AFTER WAGE-LOSS BENEFITS CONCLUDE

The Board may pay further wage-loss benefits to a worker after the worker's temporary disability resolves or stabilizes as a permanent impairment.

Where a recurrence of a worker's injury, mental disorder or occupational disease, or a significant change in a worker's medical condition previously determined to be compensable, causes a further period of temporary disability, wage-loss benefits may again become payable (section 125(1)). This is distinct from a situation where the worker may become entitled to wage-loss benefits due to a further work injury.

5.1 Worker in Receipt of Permanent Disability Benefits

It is recognized that no condition is ever absolutely stable or permanent; there will commonly be some degree of fluctuation. Nevertheless, permanent disability benefits will be granted when, though there may be some changes, the condition will, in the reasonably foreseeable future, remain essentially the same. The fluctuations in the condition of a worker receiving permanent disability benefits may be such as to require the worker to stay off work from time to time. The question then arises whether wage-loss benefits should be paid for these periods.

If the fluctuations in the worker's condition are within the range normally to be expected from the condition for which the worker has been granted permanent disability benefits, no wage-loss benefits are payable. The permanent disability benefits are intended to cover such fluctuations. Wage-loss benefits are only payable in cases where there is medical evidence of a significant deterioration in the worker's condition which not only goes beyond what is normally to be expected, but is also a change of a temporary nature. If the change is a permanent one, the Board may make a new decision on the

amount of the worker's permanent disability benefits under sections 195 and 196. (See the policy in Item C14-102.01.)

5.2 Impact of Recurrence or Significant Change on Wage-Loss Benefits

If the recurrence or significant change results in a further period of temporary disability within three years of the date of injury, the Board may pay further temporary disability wage-loss benefits. This is so, even if the worker would not have been working for some period during the time of the recurrence or significant change. The fact that the worker is, for example, on strike at the time of the recurrence or significant change, does not prevent the Board from paying wage-loss benefits for temporary disability. The Board uses Item C9-70.00 to set the rate for the wage-loss benefits.

If the recurrence or significant change occurs after a lapse of three years following the date of injury, the Board uses Item C9-70.00 to determine whether the worker has experienced an actual or potential loss and set the rate for wage-loss benefits.

EFFECTIVE DATE: January 1, 2024

AUTHORITY: Section 201 of the *Act*.

CROSS REFERENCES:
Item C5-33.10, *Wage-Loss Benefits For Temporary Total Disability*;
Item C5-33.20, *Wage-Loss Benefits For Temporary Partial Disability*;
Item C5.34.10, *Payment of Wage-Loss Benefits* (Section 3.1 No Reimbursement of Vacation Pay or Termination Pay);
Item C5-34.20, *Wage-Loss Benefits and Retirement Date*;
Item C6-37.00, *Permanent Total Disability Benefits*;
Item C6-41.00, *Duration of Permanent Disability Periodic Payments*;
Item C9-70.00, *Average Earnings on Reopened Claims*;
Item C10-73.00, *Direction, Supervision, and Control of Health Care*;
Item C10-74.00, *Reduction or Suspension of Compensation*;
Item C11-88.50, *Vocational Rehabilitation – Formal Training*;
Item C14-102.01, *Changing Previous Decisions – Reopenings*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:
July 4, 2025 – Housekeeping changes related to the reformatting and renumbering of Chapter 9, *Average Earnings*, of the *Rehabilitation Services & Claims Manual, Volume II*.
May 1, 2024 – Housekeeping.
This policy consolidates former policy items #34.12, #34.41, #34.50, #34.51, #34.52, #34.53, #34.54, #34.55, and the non-retirement date duration language from former policy item #35.30, and includes concepts from former policy item #34.32, of the *Rehabilitation Services & Claims Manual*, Volume II, consequential to reformatting and renumbering the policies in Chapter 5.
Former policy item #34.51 was amended to reflect amendment to health care provisions of the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), on October 21, 2020; and to delete references to Board officers on June 1, 2009.
Former policy item #34.52 had references to Human Resources and Skills Development Canada updated on June 1, 2009; and policy cross-references and housekeeping changes updated on November 1, 2002.
Former policy item #34.54 had references to Board officers deleted on

June 1, 2009; and references to pension review deleted on March 3, 2003.
Former policy items #34.55 and #35.30 were amended to provide guidance regarding the legal issues of standard of proof, evidence, and causation, on February 1, 2020.

APPLICATION: Applies to all decisions made on or after January 1, 2024.

RE: Payment of Wage-Loss Benefits **ITEM: C5-34.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the payment or reimbursement of wage-loss benefits.

2. The Act

Section 134(4):

> If an injury disables a worker from earning full wages at the work at which the worker was employed, compensation other than a health care benefit is payable under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] from the first working day following the day of the injury.

Section 201(2), in part:

> … the Board may not make a periodic payment to a worker under this Division [Division 6 of Part 4 of the *Act* – Compensation for Worker Disability] if the worker ceases to have the disability for which the periodic payment is to be made.

Section 233:

> (1) In setting the amount of a periodic payment of compensation to a worker, the Board must consider payments, allowances or benefits that the worker may receive from the worker's employer during the period of the worker's disability, including a pension, gratuity or other allowance provided wholly at the expense of the employer.
>
> (2) An amount deducted under this section from the compensation otherwise payable to a worker may be paid to the worker's employer out of the accident fund.

POLICY

1. GENERAL

Temporary partial disability wage-loss benefits are paid in the same manner as temporary total disability wage-loss benefits.

The Board calculates wage-loss benefits on the basis of a worker's "average net earnings". The determination of average net earnings is dealt with by policy in Chapter 9.

The Board decides whether wage-loss benefits are payable, the duration of those payments, and their amount. The Board follows the procedures and rules of evidence set out by policy in Chapter 12 to make these decisions.

2. PAYING WAGE-LOSS BENEFITS

Wage-loss benefits usually commence shortly after the initial acceptance of a claim, and may be for total disability under section 191 or partial disability under section 192.

If a temporary disability results from a worker's injury, compensation is payable from the first working day following the day of the injury.

Payments of wage-loss benefits are usually made every two weeks. The cheques are mailed to the worker's home address or, if the worker elects, directly to the worker's bank by electronic direct bank deposit. If a payment has been lost or stolen, or otherwise not received or cashed by the worker, the worker may request a reissue of the payment, but the Board will require a written and signed declaration of this from the worker before a reissue will take place.

If a worker disagrees with the amount of wage-loss benefits and returns the cheque, or refuses to accept the cheque, the Board does not negotiate regarding the acceptance of the cheque. In such circumstances the worker is notified of the right to request a review from the Review Division with regard to the matter on the claim to which there is an objection. This policy also applies to those cases where a worker has elected to receive the wage-loss benefit cheque by electronic direct bank deposit.

3. REIMBURSING EMPLOYERS FOR AMOUNTS DEDUCTED FROM COMPENSATION

The *Act* permits the Board to reimburse the employer for any amount deducted from a worker's periodic payments for which the employer has paid the worker, under section 233(2). The section is permissive, not mandatory.

Section 233(2) does not require the Board to deduct from a worker's wage-loss benefits every payment the employer makes to the worker, nor to pay the employer any amounts deducted as a result of payments an employer makes to the worker during a worker's period of temporary disability. The *Act* requires only that the Board consider the matter.

In general, the Board reimburses an employer who continues paying full wages to a worker in an amount equal to the compensation that would otherwise be paid to the worker. No payment is made to the employer for the difference between the amount of compensation and the worker's regular salary.

One exception is for the Federal Government. The Board does not reimburse the Federal Government under section 233(2) if it is the injury employer. If the Federal Government is not continuing to pay full salary to the worker, the Board pays the wage-loss benefits to the worker.

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

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

3.1 No Reimbursement of Vacation Pay or Termination Pay

If a vacation period or statutory holiday occurs while an employer continues to pay the full wages of a worker entitled to wage-loss benefits, the Board continues to reimburse the employer the wage-loss benefit amounts to which the worker would otherwise be entitled.

The Board does not deduct a worker's termination of employment payment required by law (legislative or contractual) from a worker's temporary disability wage-loss benefits. As such, the Board does not reimburse the employer for the termination payments under section 233(2). This is because the termination payment required by law is not a voluntary payment by the employer.

EFFECTIVE DATE:	January 1, 2024
AUTHORITY:	Section 233 of the *Act*.
CROSS REFERENCES:	Item C5-33.00, *Introduction to Compensation for Temporary Disability*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	This policy consolidates former policy items #34.40, #34.60, and #35.40, and includes concepts from former policy items #33.00 and #34.41, of the *Rehabilitation Services & Claims Manual*, Volume II, consequential to reformatting and renumbering the policies in Chapter 5. Former policy item #34.40 had the statement deleted that no refund will be made to the employer where the employer continues to pay 25% or less of the worker's salary during the disability, on December 1, 2010. Former policy item #34.60 had references to Board officers deleted, and references to funds transfers included, on June 1, 2009; and references to the Review Division included on March 3, 2003.
APPLICATION:	Applies to all decisions made on or after January 1, 2024.

RE:	Wage-Loss Benefits and Retirement Date	ITEM:	C5-34.20

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the determination of a worker's retirement date for the purposes of the duration of the wage-loss benefits decision under section 201.

2. The Act

Section 201:

(1) Subject to subsection (2), periodic payment of compensation under this Division [Division 6 of Part 4 of the *Act* – Compensation for Worker Disability] may be paid to an injured worker only as follows:

(a) if the worker is under 63 years of age on the date of the injury, until the later of the following:

(i) the date the worker reaches 65 years of age;

(ii) if the Board is satisfied the worker would retire after reaching 65 years of age, the date the worker would retire, as determined by the Board;

(b) if the worker is 63 years of age or older on the date of the injury, until the later of the following:

(i) 2 years after the date of the injury;

(ii) if the Board is satisfied that the worker would retire after the date referred to in subparagraph (i), the date the worker would retire, as determined by the Board.

(2) As a restriction on subsection (1), the Board may not make a periodic payment to a worker under this Division [Division 6 of Part 4 of the *Act* – Compensation for Worker Disability] if the worker ceases to have the disability for which the periodic payment is to be made.

(3) A determination made under subsection (1)(a)(ii) as to a date on which a worker would retire after reaching age 65 may be made after a worker has

reached age 63, and the Board may, when making the determination, consider the worker's circumstances at the time of that determination.

3. Workers Compensation Amendment Act, 2020 (Bill 23 of 2020)

Section 36:

> A determination may be made under section 201(3) of the *Workers Compensation Act*, as added by section 18 of this Act, whether or not a determination has been made under section 201(1) of that Act before the date section 18 of this Act comes into force [January 1, 2021].

POLICY

1. GENERAL

The duration of wage-loss benefits may be affected by the worker's age at the date of injury.

For the purposes of temporary disabilities, section 201(1) provides for the payment of wage-loss benefits:

- if a worker is under 63 years of age on the date of the injury, until the date the worker reaches 65 years of age, or
- if a worker is 63 years of age or older on the date of the injury, until two years after the date of the injury.

If the Board is satisfied a worker would retire after these dates, section 201(1) permits the Board to continue to pay wage-loss benefits to the date the worker would retire if the worker had not been injured.

For the purpose of this policy, a worker is generally considered to be retired when the worker substantially withdraws from the workforce and receives retirement income from one or more retirement-like sources (e.g., CPP, OAS, employer pension plan, RRSP or other personal savings).

2. EVIDENCE

As age 65 is the established retirement date under the *Act* if a worker is under age 63 on the date of injury, to continue to pay wage-loss benefits after the age of 65, the evidence must support a finding that the worker would work past age 65. Evidence is also required so that the Board can establish the worker's retirement date for the purposes of concluding wage-loss benefits payments. The standard of proof under section 339(3) is "at least as likely as not" as described by policy in Item C12-97.00.

The gathering and weighing of evidence generally is covered by policy in Items C12-97.00 through C12-97.50.

The issue for the Board to determine is whether it is “at least as likely as not” that the worker would have retired after age 65 if the injury had not occurred. The Board considers the worker’s statement of intention to retire after age 65, but must determine whether it is “at least as likely as not” that the worker would have retired later than age 65. The Board may consider the worker's circumstances at the time of that determination. This means the Board may consider pre- and post-injury evidence to establish the date the worker would retire.

However, post-injury circumstances that happened only because of the injury are not relevant to determining when the worker would have retired if the injury had not occurred. Post-injury circumstances are relevant if they would have occurred even if the worker had not been injured.

When determining whether a worker would retire after age 65, the weight the Board gives to the types of evidence will vary with the circumstances of each claim. The following are examples of the kinds of evidence the Board may consider:

- names of the employer or employers, a description of the type of employment, the expected duration of employment, and information from the identified employer or employers to confirm their intention to employ the worker after the worker reached age 65 and that employment would be available;
- a statement from a bank or financial institution outlining a financial plan and post-age 65 retirement date;
- an accountant’s statement verifying a long-term business plan (for self-employed workers), indicating continuation of work beyond age 65;
- information provided from the worker’s employer, union or professional association regarding the normal retirement age for workers in the same occupation and whether there are incentive plans for workers working beyond age 65;
- information from the employer about whether the worker would be covered under a pension plan provided by the employer, and the terms of that plan;
- information from the employer or union on whether there was or is a collective agreement in place setting out the normal retirement age;
- information regarding whether the worker would have the capacity to perform the work;

- financial obligations of the worker, such as a mortgage or other debts;
- family commitments and/or circumstances of the worker; and
- an outstanding lease on a commercial vehicle (for self-employed workers).

This is not a conclusive list of the types of evidence that may be considered. The Board will consider any other relevant information in determining whether a worker would work past age 65 and at what date the worker would retire.

If a worker is 63 years of age or older on the date of the injury, the established retirement date under the *Act* is two years after the date of injury. In these cases, the issue for the Board to determine is whether it is "at least as likely as not" that the worker would have retired later than two years after the date of injury if the injury had not occurred. The Board applies the same evidentiary principles to this determination as for workers who are under age 63 at the date of injury. In particular, the Board may consider the worker's circumstances at the time of that determination, which means the Board may consider pre- and post-injury evidence to establish the date the worker would retire. Post-injury circumstances are relevant if they would have occurred even if the worker had not been injured.

3. WHEN DETERMINATION IS MADE

In most cases, the determination of a worker's retirement date is made as part of the decision regarding the duration of permanent disability benefits under section 201.

In some circumstances, the determination of a worker's retirement date may be made prior to the decision on the duration of permanent disability benefits, when the determination is made as part of a decision on the duration of the worker's wage-loss benefits. In these cases, the retirement date in the decision on the duration of wage-loss benefits will also apply to the resulting permanent disability benefits, if provided.

The determination of a worker's retirement date for the purposes of the duration of wage-loss benefits decision under section 201 is made once, unless section 36 of the *Workers Compensation Amendment Act, 2020*, applies. Under section 36, another determination may be made after the worker has reached age 63 if:

- the worker was under 63 years of age on the date of injury,
- a previous determination was made under section 201(1) before January 1, 2021, and
- the worker has not reached the date of retirement as previously determined by the Board.

4. WHEN PAYMENTS CONCLUDE

At the worker's date of retirement, as determined by the Board, wage-loss benefits will conclude even if the worker's temporary disability remains.

EFFECTIVE DATE:	February 1, 2026
AUTHORITY:	Section 201 of the *Act*.
CROSS REFERENCES:	Item C6-41.00, *Duration of Permanent Disability Periodic Payments;* Item C12-97.00, *Evidence – General* Item C12-97.10, *Evidence Evenly Weighted*; Item C12-97.20, *Presumptions*; Item C12-97.30, *Medical Evidence*; Item C12-97.40, *Evidence – Other Matters*; Item C12-97.50, *Surveillance*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	February 1, 2026 − Amended to reference the general evidence policies and further clarify evidentiary principles for workers 63 and older at the date of injury. December 1, 2025 − Housekeeping change to update internal cross-reference, consequential to reformatting and renumbering Chapter 12, *Claims Procedures.* January 1, 2024 − Amended to revise the interpretation of "would retire" in section 201 and add additional guidance for workers 63 and older at the date of injury. This policy replaces the retirement date language from former policy item #35.30, consequential to reformatting and renumbering the policies in Chapter 5. February 1, 2022 − Housekeeping change to former policy item #35.30 to correct legislative wording. January 1, 2021 − Former policy item #35.30 amended to reflect amendment to retirement age determination provision of the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), and to update references to the *Act* consequential to implementing the permanent partial disability benefits provisions of Bill 23 of 2020. April 6, 2020 − Housekeeping changes to former policy item #35.30 consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – former policy item #35.30 amended to provide guidance on legal issues of standard of proof, evidence, and causation.
APPLICATION:	Applies to all decisions, including appellate decisions, made on or after February 1, 2026.

RE: Introduction to Return to Work Obligations **ITEM: C5-35.00**

BACKGROUND

1. Explanatory Notes

This policy outlines key terms and provides an overview of the return to work obligations established for workers, employers, and the Board under sections 154.1 to 154.6 of the *Act*.

In addition to the obligations created by the *Act*, and outlined in this policy, all employers have an obligation to comply with human rights legislation to accommodate workers with disabilities. This obligation is set out in British Columbia's *Human Rights Code*, and for federally regulated employers, in the *Canadian Human Rights Act*.

2. The Act

Section 154.1:

> (1) In this Division [Division 3.1 of Part 4 of the *Act* – Return to Work and Other Duties in Relation to Injured Workers], **"injury"** includes an occupational disease and a mental disorder.
>
> (2) This Division [Division 3.1 of Part 4 of the *Act* – Return to Work and Other Duties in Relation to Injured Workers] applies in relation to an employer and a worker of the employer if, because of an injury that arose out of and in the course of the worker's employment, the worker has been disabled from earning full wages at the work at which the worker was employed at the time of the injury.

Section 154.2(6):

> If a worker fails to comply with subsection (2) [setting out the worker's duty to cooperate], the Board may reduce or suspend payments of compensation to the worker until the worker complies.

Section 154.3, in part:

> (1) Except as provided in subsection (2), this section applies in relation to an employer and a worker of the employer if the worker has been employed by the employer, on a full- or part-time basis, for a continuous period of at least 12 months before the date the worker was injured.

(2) This section does not apply in relation to the following:

(a) a person who is a worker only because the person is deemed under the Act to be a worker;

(b) an employer who regularly employs fewer than 20 workers;

(c) a class of employers or workers or an industry or class of industries prescribed by the Lieutenant Governor in Council.

…

Section 154.5(1):

The Board may, by notice sent to an employer, impose on the employer an administrative penalty determined by the Board if the Board is satisfied on a balance of probabilities that the employer has failed to comply with a provision of section 154.2 *[duty to cooperate]* or 154.3 *[duty to maintain employment]*.

POLICY

1. KEY TERMS IN RETURN TO WORK OBLIGATIONS

The following terms are used throughout this Chapter.

1.1 Accommodation and Undue Hardship

Accommodation is the process of changing the work and/or the workplace to be consistent with the worker's functional abilities.

Under the duty to maintain employment, the employer must accommodate the worker to the point of undue hardship.

Undue hardship is the point at which it is too difficult, too expensive, or unsafe for the employer to accommodate the worker, which is determined based on the relevant facts and circumstances of each case.

1.2 Alternative Work

Alternative work is a job that is different from, but comparable to, the worker's pre-injury work and wages from that work.

Under the duty to maintain employment, once a worker is fit to carry out the essential duties of their pre-injury work, the employer has an obligation to offer to return the worker to either their pre-injury work, or to alternative work.

1.3 Suitable Work

Suitable work is work that is safe, productive, and consistent with the worker's functional abilities and skills. Suitable work arrangements may involve duties different from the pre-injury work, or some modification of the pre-injury duties and/or hours of work.

Under the duty to cooperate, the employer must identify suitable work that, if possible, restores the worker's full wages from their pre-injury work, and, where reasonable, make the suitable work available to the worker. If requested by the employer, the worker must assist in identifying suitable work. The duty to cooperate also requires the worker to not unreasonably refuse suitable work, whether it has been made available by the injury employer or another employer.

Under the duty to maintain employment, where a worker is not fit for the essential duties of their pre-injury work, the employer must offer the first suitable work that becomes available.

The terms suitable work and suitable occupation are both used in the *Act*, and in some circumstances the meanings of these terms overlap. Where a worker's disability is temporary, suitable work will generally be considered a suitable occupation for the purposes of determining entitlement under section 192 (see policy in Item C5-33.20). However, where a worker's disability is permanent, suitable occupation includes a focus on the reasonable availability of the work over the long term, and on maximizing the worker's long-term earnings potential (see policy in Item C6-40.00). These considerations are not requirements for the purposes of suitable work.

2. GENERAL

The Board recognizes the value of maintaining an injured worker's positive connection to the workplace. Collaboration between workers and employers, and timely intervention from the Board where required, are essential components to successful recovery and return to work outcomes, and help minimize the disruptive impact of workplace injuries on workers and employers. Sections 154.2 [duty to cooperate] and 154.3 [duty to maintain employment] set out the obligations of workers, employers, and the Board to assist injured workers in their return to, or continuation of, work.

The obligations under sections 154.2 and 154.3 apply only if the worker has been disabled from earning full wages at the worker's pre-injury work because of an injury arising out of and in the course of employment. For the purpose of these obligations, employer means the injury employer, unless otherwise specified. Injury includes an occupational disease and a mental disorder.

This policy introduces the concepts and obligations under the duty to cooperate and the duty to maintain employment, and should be read in conjunction with those policies.

See also policy in Items C5-35.10, C5-35.20, and C5-35.30.

3. DUTY TO COOPERATE

Section 154.2 creates a duty for all employers and workers to cooperate in the timely and safe return to, or continuation of, work (see policy in Item C5-35.10).

The employer must cooperate by contacting and maintaining communication with the worker, identifying suitable work, and providing the Board with relevant information regarding the worker's return to, or continuation of, work. The employer must also cooperate with the worker and the Board by, where reasonable, making available the suitable work it has identified.

The worker must cooperate by contacting and maintaining communication with the employer, assisting with identification of suitable work if requested by the employer, and providing the Board with relevant information regarding their return to, or continuation of, work.

The worker must also cooperate with the Board by not unreasonably refusing suitable work when it has been made available by the injury employer, or by another employer.

4. DUTY TO MAINTAIN EMPLOYMENT

Section 154.3 creates a duty for some employers, in certain situations, to maintain the employment of an injured worker (see policy in Item C5-35.20). Generally, an employer has a duty to maintain employment of a worker if:

- the worker has been employed by the employer for a continuous period of at least 12 months; and
- the employer regularly employs 20 or more workers.

Depending on the circumstances, maintaining employment may involve returning the worker to their pre-injury work, providing alternative work, or providing suitable work.

The duty to maintain employment includes an obligation on the employer to make any change to the work and/or the workplace necessary to accommodate an injured worker, to the point of undue hardship.

5. CONCURRENT DUTIES

Employers with a duty to maintain employment also have a duty to cooperate.

6. CONSEQUENCES FOR FAILURE TO COMPLY WITH OBLIGATIONS

Where a worker fails to comply with the obligations under the duty to cooperate, the Board may reduce or suspend the worker's compensation under section 154.2(6) (see policy in Item C5-35.10).

Where an employer fails to comply with the obligations under either the duty to cooperate or the duty to maintain employment, the Board may levy an administrative penalty under section 154.5. The process for imposing administrative penalties is outlined in policy in Item C5-35.30.

EFFECTIVE DATE:	January 1, 2024
AUTHORITY:	Division 3.1 of the *Act*.
CROSS REFERENCES:	Item C5-33.20, *Wage-Loss Benefits For Temporary Partial Disability*; Item C5-35.10, *Duty to Cooperate*; Item C5-35.20, *Duty to Maintain Employment*; Item C5-35.30, *Penalties for Failure to Comply with the Duty to Cooperate or Duty to Maintain Employment*; Item C6-40.00, *Section 196 Permanent Partial Disability Benefits*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	May 1, 2024 – Housekeeping change to update internal cross reference. January 1, 2024 – Policy created to implement Division 3.1 of the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41).
APPLICATION:	Applies to all decisions made on or after January 1, 2024.

RE: Duty to Cooperate **ITEM: C5-35.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the worker and employer's duty to cooperate in the worker's timely and safe return to, or continuation of, work.

In addition to the obligations imposed by section 154.2 of the *Act,* and outlined in this policy, all employers have an obligation to comply with human rights legislation to accommodate workers with disabilities. This obligation is set out in British Columbia's *Human Rights Code*, and, for federally regulated employers, in the *Canadian Human Rights Act*.

2. The Act

Section 154.1:

See Item C5-35.00.

Section 154.2:

(1) An employer must cooperate with a worker and the Board in the worker's early and safe return to, or continuation of, work by doing the following:

(a) subject to subsection (3), contacting the worker as soon as practicable after the worker is injured and maintaining communication with the worker;

(b) identifying suitable work for the worker that, if possible, restores the full wages the worker was earning at the worker's pre-injury work;

(c) providing the Board with information the Board requires in relation to the worker's return to, or continuation of, work;

(d) any other thing required by the Board.

(2) A worker must cooperate with an employer and the Board in the worker's early and safe return to, or continuation of, work by doing the following:

(a) subject to subsection (3), contacting the employer as soon as practicable after the worker is injured and maintaining communication with the employer;

(b) on request of the employer, assisting the employer to identify suitable work for the worker that, if possible, restores the full wages the worker was earning at the worker's pre-injury work;

(c) providing the Board with information the Board requires in relation to the worker's return to, or continuation of, work;

(d) any other thing required by the Board.

(3) The obligations referred to in subsections (1) (a) and (2) (a) do not apply if, having regard to all of the circumstances, contact and communication between the employer and the worker are likely to imperil or delay the worker's recovery.

(4) The Board must determine whether an employer or worker has failed to comply with this section if

(a) the employer or worker notifies the Board of a dispute regarding compliance, and

(b) the dispute cannot otherwise be resolved.

(5) A determination under subsection (4) must be made within 60 days after the Board is notified of the dispute or within a longer period that the Board may determine.

(6) If a worker fails to comply with subsection (2), the Board may reduce or suspend payments of compensation to the worker until the worker complies.

Section 154.4:

(1) If section 154.2 or 154.3 conflicts with a term of a collective agreement that is binding on an employer in relation to a worker, the section in conflict prevails to the extent that it affords the worker a greater benefit than the term of the collective agreement.

(2) Subsection (1) of this section does not operate to displace a term of the collective agreement that deals with seniority.

Section 154.5(1):

See Item C5-35.00.

Section 191(1):

Subject to subsection (2), if a temporary total disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the worker's average net earnings.

Section 192(1):

Subject to subsection (2), if a temporary partial disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the difference between

(a) the worker's average net earnings before the injury, and

(b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:

(i) the average net earnings that the worker is earning after the injury;

(ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury.

POLICY

1. GENERAL

The Board supports timely and safe return to, or continuation of, work as an important component of a worker's rehabilitation, and recognizes the value of maintaining an injured worker's positive connection to the workplace.

2. WHEN DUTY TO COOPERATE APPLIES

The duty to cooperate under section 154.2 of the *Act* applies to an employer and a worker of the employer if, because of an injury that arose out of and in the course of the worker's employment, the worker has been disabled from earning full wages at the work at which the worker was employed at the time of the injury. In this policy, employer means the injury employer, unless otherwise specified. Injury includes an occupational disease and a mental disorder.

The duty to cooperate applies to an employer regardless of whether the duty to maintain employment under section 154.3 applies.

Where section 154.2 conflicts with a term of a collective agreement governing the relationship between the worker and the employer, section 154.2 prevails to the extent that it affords the worker a greater benefit than the term of the collective agreement. However, this does not displace a term of the collective agreement that deals with seniority.

3. DUTY TO COOPERATE

The employer and the worker must cooperate with each other and with the Board in the worker's early and safe return to, or continuation of, work.

The employer must cooperate by:

- contacting the worker as soon as practicable after the worker is injured. As soon as practicable means as soon as is reasonably capable of being done.
- maintaining communication with the worker. This means maintaining communication during the worker's recovery, as appropriate in the circumstances.
- identifying suitable work for the worker that, if possible, restores the full wages the worker was earning at the worker's pre-injury work.
- providing the Board with information the Board requires in relation to the worker's return to, or continuation of, work.

The worker must cooperate by:

- contacting the employer as soon as practicable after the worker is injured. As soon as practicable means as soon as is reasonably capable of being done.
- maintaining communication with the employer. This means maintaining communication during the worker's recovery, as appropriate in the circumstances.
- on request of the employer, assisting the employer to identify suitable work that, if possible, restores the full wages the worker was earning at the worker's pre-injury work.
- providing the Board with information the Board requires in relation to the worker's return to, or continuation of, work.

Sections 154.2(1)(d) and 154.2(2)(d) enable the Board to create any other requirements of an employer or a worker to elicit their cooperation with each other and with the Board in the worker's early and safe return to, or continuation of, work. For the purposes of these sections, the Board requires:

- the employer to cooperate with the worker and Board by, where reasonable, making available suitable work the employer has identified; and

- the worker to cooperate with the Board by not unreasonably refusing suitable work when it has been made available by any employer, which generally means an employer with whom the worker has an existing employment relationship.

The worker and the employer do not have to contact or maintain communication with each other if, having regard to all of the circumstances, the contact and communication are likely to imperil or delay the worker's recovery.

4. SUITABLE WORK

4.1 Suitable Work – General

Suitable work is work that is safe, productive, and consistent with the worker's functional abilities and skills. More specifically:

- The work must be safe, in that it does not pose a health and safety risk to the worker (i.e., it will neither harm the worker nor slow recovery) or to others.

- The work must be productive; token or demeaning tasks are considered detrimental to the worker's rehabilitation.

- The work must be within the worker's functional abilities and medical restrictions.

- The worker has, or is reasonably able to acquire, the necessary skills, competencies, or qualifications to perform the work.

Suitable work arrangements may involve duties different from the pre-injury work, or some modification of the pre-injury duties and/or hours of work. Consultation with the worker, employer, physicians, qualified practitioners and/or other recognized health care professionals, and the union may be part of identifying suitable work.

4.2 Suitable Work – Duty to Cooperate

The successful development of suitable work arrangements depends on the cooperation of all parties in the workplace. If possible, suitable work should restore the full wages the worker was earning at the worker's pre-injury work.

Suitable work can be made available by the employer on, or soon after, the date of injury, or after the worker has participated in some form of medical treatment or rehabilitation. The worker must not unreasonably refuse suitable work when it has been made available by any employer.

In cases where the worker is not fit to work, or no suitable work is identified or is currently available, the worker and the employer are expected to maintain regular communication, as appropriate, in preparation for a future return to work.

5. DURATION OF THE DUTY TO COOPERATE

The worker and the employer's duty to cooperate in the worker's timely and safe return to, or continuation of, work begins from the date of injury and continues throughout the worker's claim.

Where there is no longer an employment relationship between the worker and the employer, the worker continues to have a duty to cooperate with the Board.

6. BOARD INVOLVEMENT

The worker and the employer are encouraged to work together to resolve disputes regarding compliance with the duty to cooperate.

If the worker or the employer notifies the Board of a dispute which cannot otherwise be resolved, the Board must determine if the worker and/or the employer failed to comply with the duty to cooperate. The Board must make a determination within 60 days after the Board is notified of the dispute, or within a longer period that the Board may determine.

The Board may also determine compliance on its own initiative at any time.

6.1 Board Determinations – Suitable Work and Reasons for Refusal

Where the worker refuses work the employer has made available, the Board first examines whether the work meets the criteria for suitable work. The Board's determination is based on, but not limited to, a detailed description of the work that has been made available, the work requirements, and information outlining the worker's functional abilities and medical restrictions.

Where a worker refuses suitable work, the Board considers the reasons for refusal and determines if they are reasonable. In making this determination, the Board considers the requirements of the work, evidence regarding the worker's functional abilities and medical restrictions, and additional factors or evidence relevant to the case, including but not limited to, transportation and dependant care.

Transportation or dependant care issues may be considered if they impact the worker's ability to accept suitable work due to the workplace injury or a change in the hours and/or location of the work an employer has made available, including (but not limited to) where:

- the ability of the worker to commute to the suitable work location is significantly impacted;

- the distance the worker must travel to get to the suitable work location is significantly greater than the distance to the pre-injury work location; or

- dependant care arrangements would be significantly different from the pre-injury arrangements.

If a worker is working towards an employment objective under a rehabilitation plan, the worker is not expected to accept lower paying suitable work in the interim, if the worker is cooperating in good faith and taking the suitable work would negatively compromise the rehabilitation plan. In these cases, a refusal of suitable work will generally not be considered unreasonable.

Where there is a dispute about whether the work that has been made available is within the worker's functional abilities or medical restrictions, failing to provide details of the work duties to the physician, qualified practitioner, or other recognized health care professional will generally be considered an unreasonable refusal.

Where the Board determines the worker's refusal of suitable work is reasonable, this will not be considered a failure to comply with the duty to cooperate.

7. CONSEQUENCES FOR FAILURE TO COMPLY WITH THE DUTY TO COOPERATE

Failure to comply with the duty to cooperate may result in:

- a reduction or suspension of the worker's compensation payments under section 154.2(6), or

- an administrative penalty on the employer under section 154.5 and as outlined in policy in Item C5-35.30.

7.1 Reduction or Suspension of Benefits

If the Board determines the worker failed to comply with the duty to cooperate, the Board may reduce or suspend the worker's compensation payments under section 154.2(6). The Board must, in all cases, make the worker aware of the reasons for the reduction or suspension of compensation payments.

Generally, when compensation payments are reinstated following a period of reduction or suspension, the payments are reinstated prospectively from the date the worker started complying with the obligations under the duty to cooperate.

7.1.1 Reduction of Benefits for Failure to Comply with Obligation to Not Unreasonably Refuse Suitable Work

The worker has a duty to not unreasonably refuse suitable work when it has been made available by any employer.

If the Board determines the worker's refusal of suitable work is not reasonable, this will generally be considered a failure to comply with the duty to cooperate, and the Board may reduce compensation payments to the worker.

The Board reduces the worker's compensation payments based on the principles of section 192 where the worker's disability is temporary. Compensation payments are generally reduced effective the date the work was suitable and available, as determined by the Board.

Where the worker's disability is temporary, and the worker refuses suitable work for reasons that do not constitute a failure to comply with the duty to cooperate (such as, withdrawing from the workforce for non-compensable health issues) the Board determines benefit entitlement under section 192 (see policy in Item C5-33.20).

If the worker no longer has a temporary disability, and is receiving compensation under section 155, the reduction of compensation payments is determined in accordance with policy in Item C11-88.00.

7.1.2 Suspension of Benefits for Failure to Comply with Other Obligations

This section applies if the worker fails to comply with the following duty to cooperate obligations:

- contacting the employer as soon as practicable after the worker is injured;
- maintaining communication with the employer;
- on request of the employer, assisting the employer to identify suitable work that, if possible, restores the full wages the worker was earning at the worker's pre-injury work; and
- providing the Board with information the Board requires in relation to the worker's return to, or continuation of, work.

The Board does not suspend compensation payments if the worker has taken all reasonable steps to comply. This involves consideration of what a reasonable person would have done in the circumstances.

Before compensation payments are suspended, the Board:

- informs the worker about the duty to cooperate and identifies the specific obligation(s) with which the worker is failing to comply.
- provides the worker with a reasonable opportunity to comply.

If the worker remains non-compliant, the Board issues a decision informing the worker that compensation payments are suspended due to failure to comply with the duty to cooperate. The suspension commences as of the date of the Board's decision.

7.2 Administrative Penalty

If the employer fails to comply with its obligations under the duty to cooperate, the Board may impose an administrative penalty on the employer under section 154.5 in accordance with policy in Item C5-35.30.

The Board generally does not impose an administrative penalty if the employer has taken all reasonable steps to comply. This involves consideration of what a reasonable person would have done in the circumstances.

EFFECTIVE DATE:	January 1, 2024
AUTHORITY:	Sections 154.1, 154.2, and 154.4 of the *Act*.
CROSS REFERENCES:	Item C5-33.20, *Wage-Loss Benefits For Temporary Partial Disability;* Item C5-35.00, *Introduction to Return to Work Obligations*; Item C5-35.20, *Duty to Maintain Employment*; Item C5-35.30, *Penalties for Failure to Comply with the Duty to Cooperate or Duty to Maintain Employment*; Item C10-83.00, *Transportation*; Item C10-83.10, *Subsistence Allowances*; Item C11-88.00, *Vocational Rehabilitation – Nature and Extent of Programs and Services* of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	May 1, 2024 – Housekeeping change to update internal cross reference. January 1, 2024 – Policy created to implement Division 3.1 of the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41). Section 154.2 comes into effect on January 1, 2024, and applies as set out in section 13 of Bill 41.
APPLICATION:	Applies to all decisions made on or after January 1, 2024, in relation to a worker who sustained an injury (as defined in section 154.1(1) of the *Act*) on or after January 1, 2022, except that for injuries sustained before January 1, 2024, policy on the obligation to contact referred to in sections 154.2(1)(a) and (2)(a) of the *Act* applies as soon as practicable after January 1, 2024 and not as soon as practicable after the worker is injured.

RE: Duty to Maintain Employment **ITEM: C5-35.20**

BACKGROUND

1. Explanatory Notes

This policy provides guidance regarding an employer's duty to maintain employment.

In addition to the obligations imposed by section 154.3 of the *Act,* and outlined in this policy, all employers have an obligation to comply with human rights legislation to accommodate workers with disabilities. This obligation is set out in British Columbia's *Human Rights Code*, and for federally regulated employers, in the *Canadian Human Rights Act*.

2. The Act

Section 154.1:

See Item C5-35.00.

Section 154.3:

(1) Except as provided in subsection (2), this section applies in relation to an employer and a worker of the employer if the worker has been employed by the employer, on a full- or part-time basis, for a continuous period of at least 12 months before the date the worker was injured.

(2) This section does not apply in relation to the following:

(a) a person who is a worker only because the person is deemed under the Act to be a worker;

(b) an employer who regularly employs fewer than 20 workers;

(c) a class of employers or workers or an industry or class of industries prescribed by the Lieutenant Governor in Council.

(3) If a worker is fit to work but not fit to carry out the essential duties of the worker's pre-injury work, an employer must offer to the worker the first suitable work that becomes available.

(4) If a worker is fit to carry out the essential duties of the worker's pre-injury work, an employer must

(a) offer that pre-injury work to the worker, or

(b) offer to the worker alternative work of a kind and at wages that are comparable to the worker's pre-injury work and wages from that work.

(5) An employer must, to the point of undue hardship, make any change to the work or the workplace that is necessary to accommodate a worker.

(6) An employer's obligations under this section end as follows:

(a) all of the employer's obligations under this section end on the second anniversary of the date a worker is injured if the worker has not returned to work by that date;

(b) the employer's obligation under subsection (4) ends on the second anniversary of the date a worker is injured if, by that date, the worker is carrying out suitable work.

(7) The Board must, if an employer and a worker disagree with each other, determine

(a) whether the worker is fit to carry out suitable work or fit to carry out the essential duties of the worker's pre-injury work, and

(b) whether suitable work is available.

(8) If an employer terminates a worker's employment within 6 months after the worker begins to carry out suitable work or begins to carry out the essential duties of the worker's pre-injury work or alternative work, the employer is deemed to have failed to comply with subsection (3) or (4), as applicable.

(9) Subsection (8) does not apply if the employer can establish, to the Board's satisfaction, that the termination was unrelated to the worker's injury.

(10) The Board must, on the request of a worker, determine whether an employer has failed to comply with this section.

(11) The Board is not required to consider a request under subsection (10) if

(a) the Board considers the request has no merit, or

(b) both of the following apply:

(i) the worker's employment is terminated within 6 months after the worker begins to carry out suitable work or begins to

carry out the essential duties of the worker's pre-injury work or alternative work;

(ii) the request is made more than 3 months after the worker's employment is terminated.

(12) The Board may pay to a worker, for a period of up to one year, an amount equal to the compensation to which the worker was entitled under section 191 *[temporary total disability]* or 192 *[temporary partial disability]*, as applicable, if

(a) an employer has failed to comply with this section, and

(b) the worker is no longer entitled to the compensation under section 191 or 192.

Section 154.4:

(1) If section 154.2 or 154.3 conflicts with a term of a collective agreement that is binding on an employer in relation to a worker, the section in conflict prevails to the extent that it affords the worker a greater benefit than the term of the collective agreement.

(2) Subsection (1) of this section does not operate to displace a term of the collective agreement that deals with seniority.

Section 155(1):

To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

Section 191(1):

Subject to subsection (2), if a temporary total disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the worker's average net earnings.

Section 192(1):

Subject to subsection (2), if a temporary partial disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the difference between

(a) the worker's average net earnings before the injury, and

(b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:

(i) the average net earnings that the worker is earning after the injury;

(ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury.

POLICY

1. GENERAL

Section 154.3 provides some employers have a duty to maintain the employment of an injured worker when certain conditions are met. Depending on the circumstances, maintaining employment may involve returning the worker to their pre-injury work, providing alternative work, or providing suitable work. The duty to maintain employment includes making any change to the work or workplace necessary to accommodate a worker to the point of undue hardship.

The duty to maintain employment is in addition to an employer's duty to cooperate under section 154.2.

Where section 154.3 conflicts with a term of a collective agreement governing the relationship between the worker and the employer, section 154.3 prevails to the extent that it affords the worker a greater benefit than the term of the collective agreement. However, this does not displace a term of the collective agreement that deals with seniority.

2. WHEN DUTY TO MAINTAIN EMPLOYMENT APPLIES

The duty to maintain employment under section 154.3 applies in relation to an employer and a worker of the employer if, because of an injury that arose out of and in the course of the worker's employment, the worker has been disabled from earning full wages at the work at which the worker was employed at the time of the injury. In this policy, employer means the injury employer. Injury includes an occupational disease and a mental disorder.

In this situation, the employer has a duty to maintain employment of a worker if:

- the worker has been employed by the employer, on a full- or part-time basis, for a continuous period of at least 12 months before the date the worker was injured; and

- the employer regularly employs 20 or more workers.

The duty to maintain employment does not apply to:

- a person who is a worker only because the person is deemed under sections 5, 6, or 7 of the *Act* to be a worker; or
- a class of employers or workers or an industry or class of industries prescribed by the Lieutenant Governor in Council.

No class of employers or workers, and no industry or class of industries have been excluded from the application of these sections by the Lieutenant Governor in Council.

2.1 Continuous Employment for at Least 12 Months

In order for the employer to have a duty to maintain employment, the worker must have been employed with the employer for a period of at least 12 months before the date of injury (on a full- or part-time basis).

A worker employed by the employer for 12 months or more before the date of injury is considered to be continuously employed, unless that 12-month period was interrupted by a work cessation that severed the employment relationship.

Generally, for the duty to maintain employment, work cessations that do not sever the employment relationship include, but are not limited to:

- compensable injuries, mental disorders, or occupational diseases resulting in time off work;
- layoffs of less than three months;
- layoffs of more than three months, if the recall date was stipulated, and the recall occurs;
- sabbaticals, sick leaves, parental leaves, leaves of absence, and vacations; or
- strikes and lock-outs.

2.1.1 Workers with a Recurring Pattern of Employment Contracts

A worker with a recurring pattern of employment contracts with the employer is considered to be continuously employed where:

- There is a demonstrated pattern of extending or renewing the worker's employment over a period of at least 12 months before the date of injury; and

- The evidence does not show that the employment was officially severed with no intention to rehire the worker in the future.

The recurrence of the contracts may be consecutive, seasonal, or with minor breaks between periods of employment.

2.2 Employer Regularly Employs 20 or More Workers

Generally, the number of workers employed by the employer in British Columbia on the date of injury is considered the number of workers regularly employed. The Board may reference the number of workers reported by the employer in the most recent year to the Canada Revenue Agency.

All workers whose earnings must be reported to the Board for assessment purposes are included when determining the number of workers regularly employed.

3. DUTY TO MAINTAIN EMPLOYMENT

The nature of the employer's obligations under the duty to maintain employment depend on whether the worker is fit to carry out the essential duties of the pre-injury work or fit to work in some other capacity.

Essential duties are the duties necessary to achieve the intended outcome of the job. Factors to be considered in determining essential duties include, but are not limited to:

- how often each duty is undertaken;
- the proportion of time spent on each duty;
- the effect on the job outcome if a duty is removed;
- the effect on the work process before or after a duty, if a duty is removed;
- the current job description;
- whether the duty is critical to safety; and
- the normal productivity expected in the job (rate, range, or level of production or service expected for the job).

3.1 Worker Fit for Essential Duties

When the worker is fit to carry out the essential duties of their pre-injury work, the employer must offer the worker:

- the pre-injury work, with or without accommodation; or

- alternative work, with or without accommodation, that is comparable to the worker's pre-injury work and wages.

3.1.1 Pre-Injury Work

In some cases, the worker is fit to carry out the essential duties of their pre-injury work without accommodation. In other cases, the worker's functional abilities may impact the worker's performance of an essential duty, or may limit the worker's rate, range, or level of production. If changes to the work and/or the workplace would allow the worker to perform the duty or duties in question, the employer must accommodate the worker to the point of undue hardship.

3.1.2 Alternative Work

Alternative work is a job that is different from, but comparable to, the worker's pre-injury work and wages from that work.

When determining if the alternative work offered is comparable to the pre-injury work, the Board may consider a number of factors in addition to wages, including:

- job duties;
- skills, qualification and experience required;
- degree of physical and cognitive effort required;
- level of responsibility and supervision of other workers;
- rights and privileges associated with the position;
- bargaining unit status;
- geographic location of the alternative worksite;
- hours of work, working conditions, and right to work overtime;
- opportunities for advancement;
- employee benefits including vacation, health care, life insurance and pension benefits; and
- any other factor the Board considers relevant in a particular circumstance.

3.2 Worker Not Fit for Essential Duties

Where the worker is not fit to carry out the essential duties of their pre-injury work (with or without accommodation) but is fit to work in some capacity, the employer must offer the worker the first suitable work that becomes available.

3.2.1 Suitable Work – General

Suitable work means work that is safe, productive, and consistent with the worker's functional abilities and skills. More specifically:

- The work must be safe, in that it does not pose a health and safety risk to the worker (i.e., it will neither harm the worker nor slow recovery) or to others.
- The work must be productive; token or demeaning tasks are considered detrimental to the worker's rehabilitation.
- The work must be within the worker's functional abilities and medical restrictions.
- The worker has, or is reasonably able to acquire, the necessary skills, competencies, or qualifications to perform the work.

Suitable work arrangements may involve duties different from the pre-injury work, or some modification of the pre-injury duties and/or hours of work. Consultation with the worker, employer, physicians, qualified practitioners and/or other recognized health care professionals, and the union may be part of identifying suitable work arrangements.

3.2.2 Suitable Work – Duty to Maintain Employment

Suitable work may be offered while the worker is temporarily disabled or after the worker's condition has stabilized as a permanent condition.

If the Board determines the work offered is not suitable work, the employer must offer to the worker the first suitable work that becomes available.

In determining if suitable work is available with the employer, the Board may consider, among other things, the employer's recruitment activities and patterns on or after the date the worker is fit for suitable work (e.g., job postings, vacancies, or evidence of hirings or transfers).

If the worker unreasonably refuses an offer of suitable work, the Board determines whether the worker failed to comply with the worker's duty to cooperate under section 154.2(2)(d) (see policy in Item C5-35.10).

4. ACCOMMODATION

An employer's duty to maintain employment includes an obligation to make any change to the work and/or the workplace necessary to accommodate an injured worker, to the extent that the accommodation does not cause the employer undue hardship.

Accommodation is the process of changing the work and/or the workplace to be consistent with the worker's functional abilities. An accommodation does not have to be the change most preferred by the worker.

The employer must provide an accommodation to allow the worker to continue, or return to, work if the worker is:

- fit to carry out the essential duties of their pre-injury work with accommodation; or
- fit to work but not fit to carry out the essential duties of their pre-injury work, and a job is suitable, or can be made suitable, through accommodation.

A worker's accommodation requirements may be temporary or permanent.

The obligation to make any change to the work and/or workplace to accommodate an injured worker is ongoing. As the worker's functional abilities change, the employer's obligation also changes to correspond with the worker's changed level of function.

4.1 Undue Hardship

While employers must take all reasonable and practical steps to accommodate an injured worker, employers are not required to accommodate a worker if it would cause undue hardship. Undue hardship is the point at which it is too difficult, too expensive, or unsafe for the employer to accommodate the worker. What constitutes undue hardship is based on all relevant facts and circumstances of each case. The Board may consider any or all of the following factors when determining whether accommodating the worker would cause undue hardship:

- safety risks to the worker, other workers, or others;
- financial ability to accommodate;
- disruption of operations;
- interchangeability of the work force and facilities;
- size of the employer's operation; and
- impact on other workers.

This list is not exhaustive, and any one factor may be determinative of whether accommodating the worker would cause undue hardship. When claiming undue hardship, the employer must provide supporting evidence.

If the Board determines that undue hardship would result from accommodating the worker, the employer is not required to provide accommodation. However, the employer must consider if there are other options that would accommodate the worker without undue hardship.

In cases where the expense to accommodate the work and/or the workplace would result in undue hardship for the employer, the Board may consider paying for a portion, or the entire, cost of accommodating the worker where such payments are consistent with the *Act* and policy.

5. DURATION OF DUTY TO MAINTAIN EMPLOYMENT

Generally, the duty to maintain employment is ongoing until the second anniversary of the date of injury. As the worker's fitness to carry out the essential duties of the pre-injury work changes, the employer's obligation also changes to correspond with the worker's changed level of function.

All of the employer's obligations under the duty to maintain employment end on the second anniversary of the date the worker is injured if the worker has not returned to work by that date.

The employer's obligation to offer the pre-injury or alternative work under section 154.3(4) ends on the second anniversary of the date the worker is injured if, by that date, the worker is carrying out suitable work.

If the worker is carrying out pre-injury work, alternative work, or suitable work by the second anniversary of the date of injury, the obligation under section 154.3(5) to accommodate the worker's injury is ongoing beyond the second anniversary of the date of injury.

If the worker voluntarily severs the employment relationship, no further obligations under the duty to maintain employment generally apply.

5.1 Duration for Fixed Term Contract Workers

In most cases, the duty to maintain employment is not intended to extend the time frame of employment agreed to at the time of hire. If a worker was hired on a contract, the employer's duty to maintain employment only requires the employer to return the worker to the pre-injury work, alternative work, or suitable work for the remainder of the contract term that was interrupted by the compensable injury.

However, in cases where there is a demonstrated pattern of extending or renewing the worker's employment in the past, with little to no break in employment, the Board may conclude that the duty to maintain employment should extend beyond the term of the contract and be governed by the normal rules for duration of duty to maintain employment.

When calculating the duration of the employer's duty to maintain employment for a worker employed on a seasonal basis, the off-season period is included. However, during the off-season period, the employer's obligation may not be in effect.

5.2 Recurrence or Significant Change

Where the duty to maintain employment has not yet ended, and a worker experiences a recurrence or significant change of the compensable injury, the employer continues to be bound by the duty to maintain employment for the original duration of the obligation.

6. DISAGREEMENTS BETWEEN WORKERS AND EMPLOYERS

The worker and the employer are encouraged to work together to resolve disagreements that arise regarding the duty to maintain employment.

If the worker or the employer notifies the Board of a disagreement which cannot otherwise be resolved, the Board determines:

- whether the worker is fit to carry out the essential duties of the pre-injury work;
- whether the worker is fit to carry out suitable work; and/or
- whether suitable work is available.

7. BOARD DETERMINATIONS REGARDING COMPLIANCE

At the worker's request, the Board must determine whether an employer has complied with its duty to maintain employment. The Board may also determine employer compliance on its own initiative at any time.

Where requested, or on its own initiative, the Board determines whether the employer:

- offered work consistent with the worker's fitness to return to the pre-injury work, alternative work, or other suitable work;
- made any changes to the work and/or workplace to accommodate the worker, to the point of undue hardship; and
- maintained employment for the duration required.

The Board is not required to consider the worker's request if the Board considers the request has no merit.

7.1 Terminations After Returning to Work

If the employer terminates a worker's employment within six months of returning to work (whether the worker returns to their pre-injury work, suitable work, or alternative work), then the employer is deemed to have failed its duty to maintain employment, unless the employer can establish, on a balance of probabilities, that the termination was not related to the worker's injury.

Where a worker's employment is terminated within six months of returning to work, the worker may request the Board to determine if the employer failed its duty to maintain employment. The worker should request a determination within three months of the termination of employment. The Board may, but is not required to, consider the worker's request if the request is made more than three months after the worker's employment is terminated.

8. CONSEQUENCES FOR FAILURE TO COMPLY WITH THE DUTY TO MAINTAIN EMPLOYMENT

Failure to comply with the duty to maintain employment may result in an administrative penalty to the employer under section 154.5, and/or additional payments to the worker.

8.1 Payments to Workers

Where the employer failed to comply with the duty to maintain employment and the worker is no longer temporarily disabled, the worker may receive compensation payments under section 154.3(12) in certain circumstances. The Board has discretion to provide payments to the worker under this section equal to the compensation the worker was entitled to under section 191 or 192 for a period of up to one year.

The Board will generally not make payments under section 154.3(12) where the worker is receiving vocational rehabilitation benefits under section 155.

The Board recognizes that assisting the worker in their return to work minimizes the disruptive impact of workplace injuries. Payments under section 154.3(12) are intended to support a worker in their return to work efforts.

Payments under section 154.3(12) are discretionary, and their entitlement and continuance is generally conditional upon the active cooperation of the worker with the Board. The Board may require proof that the worker is actively seeking employment or awaiting a definite job opportunity, based on the principles in Item C11-88.30, *Vocational Rehabilitation – Job Search Assistance*. Payments under section 154.3(12) may be reduced or discontinued if the worker returns to work.

A worker may be entitled to payments under section 154.3(12) regardless of whether an administrative penalty is imposed upon the employer under section 154.5.

8.2 Administrative Penalty

If the employer fails to comply with its obligations under the duty to maintain employment, the Board may impose an administrative penalty on the employer under section 154.5 in accordance with policy in Item C5-35.30.

The Board will not impose an administrative penalty if the employer has taken all reasonable steps to comply. This involves consideration of what a reasonable person would have done in the circumstances.

EFFECTIVE DATE:	January 1, 2024
AUTHORITY:	Sections 154.1, 154.3, and 154.4 of the *Act*.
CROSS REFERENCES:	Item C5-33.20, *Wage-Loss Benefits For Temporary Partial Disability*; Item C5-35.00, *Introduction to Return to Work Obligations*; Item C5-35.10, *Duty to Cooperate*; Item C5-35.30, *Penalties for Failure to Comply with the Duty to Cooperate or Duty to Maintain Employment*; Item C11-86.00, *Vocational Rehabilitation – Eligibility Criteria*; Item C11-88.30, *Vocational Rehabilitation – Job Search Assistance*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	May 1, 2024 – Housekeeping change to update internal cross reference. January 1, 2024 – Policy created to implement Division 3.1 of the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41). Section 154.3 comes into effect on January 1, 2024, and applies as set out in section 13 of Bill 41.
APPLICATION:	Applies to all decisions made on or after January 1, 2024, in relation to a worker who sustained an injury (as defined in section 154.1(1) of the *Act*) on or after July 1, 2023, except that policy on section 154.3(8) of the *Act* does not apply in relation to a worker whose employment was terminated before January 1, 2024.

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RE:	Penalties for Failure to Comply with the Duty to Cooperate or Duty to Maintain Employment	ITEM:	C5-35.30

BACKGROUND

1. Explanatory Notes

This policy sets out administrative penalties the Board may apply under section 154.5 of the *Act* for an employer's failure to comply with the provisions of sections 154.2 (Duty to Cooperate) and 154.3 (Duty to Maintain Employment).

2. The Act

Section 154.5:

(1) The Board may, by notice sent to an employer, impose on the employer an administrative penalty determined by the Board if the Board is satisfied on a balance of probabilities that the employer has failed to comply with a provision of section 154.2 *[duty to cooperate]* or 154.3 *[duty to maintain employment]*.

(2) A notice under subsection (1) must be in the form and contain the information required by the Board.

(3) An administrative penalty under this section must not be greater than the maximum wage rate as determined under section 209 *[maximum wage rate for average earnings]*.

(4) An employer on whom an administrative penalty is imposed under this section must pay the amount of the penalty to the Board for deposit into the accident fund.

(5) If an administrative penalty under this section is reduced or cancelled by a Board decision, on a review under Part 6 *[Review of Board Decisions]* or on an appeal to the appeal tribunal under Part 7 *[Appeals to Appeal Tribunal],* the Board must

(a) refund the required amount to the employer, and

(b) pay interest on that amount calculated in accordance with the policies of the board of directors.

POLICY

1. GENERAL

The main purpose of administrative penalties under section 154.5 is to motivate the employer receiving the penalty and other employers to comply with the duty to cooperate and the duty to maintain employment. Maintaining employment relationships and facilitating timely and safe return to work lessens the disruptive impact of workplace injuries.

A penalty for non-compliance may be an amount equal to, but must not be greater than, the maximum wage rate in the year the penalty is initially imposed, as determined under section 209.

2. APPLYING A SECTION 154.5 ADMINISTRATIVE PENALTY

If the Board is satisfied on a balance of probabilities that the employer has failed to comply with the duty to cooperate and/or the duty to maintain employment, the Board may impose an administrative penalty under section 154.5. The Board considers the individual circumstances of each case when determining whether to impose a penalty.

The Board will not impose an administrative penalty if the employer has taken all reasonable steps to comply with its obligations. This involves consideration of what a reasonable person would have done in the circumstances.

Before issuing an administrative penalty, the Board will:

(a) Inform the employer about its duties under section 154.2 and/or 154.3, identify the specific obligation(s) with which the employer is failing to comply, and advise that the Board may impose an administrative penalty for the non-compliance.

(b) Provide the employer with a reasonable opportunity to comply and/or provide an explanation for non-compliance.

If the employer remains non-compliant, the Board issues a decision letter informing the employer that the Board is imposing a penalty. The letter will provide information regarding the duty the employer failed to comply with, the amount of the penalty, and the right to have the decision reviewed and appealed.

3. PENALTY AMOUNT FOR FAILURE TO COMPLY WITH THE DUTY TO COOPERATE

The penalty amount for a failure to comply with the duty to cooperate is equal to the cost of any compensation payable to the worker under sections 155, 191 and 192 of the *Act* during the period of non-compliance.

The penalty is charged at the end of each month that the employer is non-compliant, up to a total amount not exceeding the maximum wage rate under section 209.

4. PENALTY AMOUNT FOR FAILURE TO COMPLY WITH DUTY TO MAINTAIN EMPLOYMENT

The penalty amount for a failure to comply with the duty to maintain employment is based on the greater of:

- the worker's long-term average earnings as determined by the Board up to the maximum wage rate under section 209; or
- an amount equal to 50% of the maximum wage rate under section 209.

The Board may reduce the penalty for a non-compliant employer who subsequently comes into compliance. If the Board reduces the penalty, the penalty amount may be pro-rated based on the number of weeks the employer was non-compliant following the Board's decision to impose the penalty, up to a maximum of 52 weeks.

5. MULTIPLE AND CONCURRENT PENALTIES UNDER SECTION 154.5

If an employer fails to comply with the duty to cooperate or the duty to maintain employment at different periods in the same claim, the Board may impose more than one administrative penalty.

If an employer fails to comply with the duty to cooperate and the duty to maintain employment during overlapping periods in the same claim, the Board applies a single penalty. In these cases, the Board imposes the higher penalty.

6. REDUCING OR CANCELLING PENALTIES

If a penalty imposed under section 154.5 is reduced or cancelled by a Board decision, on review, or on appeal, the Board must refund the required amount to the employer and pay interest on that amount. Guidance on refunds and the payment of interest on employer overpayments is set out in policy in Item AP5-243-1 of the *Assessment Manual.*

EFFECTIVE DATE:	January 1, 2024
AUTHORITY:	Section 154.5 of the *Act*.
CROSS REFERENCES:	Item C5-35.00, *Introduction to Return to Work Obligations*; Item C5-35.10, *Duty to Cooperate*; Item C5-35.20, *Duty to Maintain Employment*, of the *Rehabilitation Services & Claims Manual*, Volume II. Item AP5-243-1, *Assessment Payments*, of the *Assessment Manual*.
HISTORY:	January 1, 2024 – Policy created to implement Division 3.1 of the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41).
APPLICATION:	Applies to all decisions made on or after January 1, 2024.

RE: Permanent Disability Benefits – General **ITEM: C6-36.00**

BACKGROUND

1. Explanatory Notes

This policy provides an overview of the statutory provisions related to permanent disability benefits.

2. The Act

Section 190:

Compensation under this Division is subject to the following provisions:

(a) section 230 *[manner of compensation payment: periodic or lump sum]*;

(b) section 231 *[payment of compensation in specific circumstances]*;

(c) section 232 *[Board authority to discontinue or suspend payments]*;

(d) section 233 *[deduction in relation to payments from employer]*.

Section 194:

(1) Subject to subsection (2), if a permanent total disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the worker's average net earnings.

(2) Compensation to be paid under this section must not be less than $2 221.30 per month. *[Note: See Note on page 1 of the Act concerning dollar amount.]*

Section 195:

(1) Subject to section 196, if a permanent partial disability results from a worker's injury, the Board must

(a) estimate the impairment of the worker's earning capacity from the nature and degree of the injury, and

(b) pay the worker compensation that is a periodic payment of an amount that equals 90% of the Board's estimate of the worker's loss of average net earnings resulting from the impairment.

(2) The minimum compensation to be paid under this section must be calculated in accordance with section 191(2) *[compensation for temporary total disability]* but to the extent only of the permanent partial disability.

(3) The Board may compile a rating schedule of percentages of impairment of earning capacity for specified injuries or mutilations that may be used as a guide in determining the compensation payable in permanent partial disability cases.

Section 196:

(1) This section applies in relation to a permanent partial disability if an amount required under section 195 is less than an amount required under this section.

(2) *Repealed*.

(3) The Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the difference between

(a) the average net earnings of the worker before the injury, and

(b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:

(i) the average net earnings that the worker is earning after the injury;

(ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury.

POLICY

A. INTRODUCTION

The Board pays permanent disability benefits if a worker fails to completely recover from a work-related injury or occupational disease, and is left with a permanent residual disability. The entitlement to permanent disability benefits commences at the point when the worker's temporary disability under the claim ceases and the condition

stabilizes. The permanent disability may be total (section 194) or partial (sections 195 and 196).

Permanent disability benefits are calculated on the basis of a worker's long term "average net earnings". The computation of long term average net earnings is dealt with in Chapter 9.

Section 190 states that all compensation under Division 6 of Part 4 of the *Act* – Compensation for Worker Disability − is subject to sections 230, 231, 232, and 233.

B. TRANSITIONAL PROVISIONS FOR PERMANENT DISABILITY BENEFITS (see Item C1-1.00)

The rules for determining whether the law and policy in effect immediately prior to June 30, 2002 (subject to subsequent amendments) apply, or those in effect on or after that date, in relation to permanent disability benefits for injured workers, are set out in Item C1-1.00.

EFFECTIVE DATE:	January 1, 2021
AUTHORITY:	Sections 190, 194, 195, 196, and 229 of the *Act.*
CROSS REFERENCES:	Item C1-1.00, *Scope of Manual*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – Housekeeping change to update internal cross-references, consequential to reformatting and renumbering Chapter 1, *Scope of Volume II of this Manual*. January 1, 2021 – This policy resulted from the consolidation of former policy items #36.00 and #36.10, consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
APPLICATION:	Applies to all decisions, including appellate decisions, made on or after January 1, 2021**.**

RE: Canada Pension Plan Disability Benefits **ITEM: C6-36.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on how Canada Pension Plan ("CPP") disability benefits are deducted from permanent disability benefits.

2. The Act

Section 202:

(1) This section applies to a worker who receives

(a) a periodic payment of compensation under section 194(1), 195(1) or 196(1) *[compensation for permanent disability]* in respect of an injury, and

(b) a disability benefit under the *Canada Pension Plan* in respect of the injury.

(2) Subject to sections 194(2), 195(2) and 198(5) *[minimum compensation payments]*, the Board must deduct from a periodic payment referred to in subsection (1)(a), an amount that equals 50% of any disability benefit paid as referred to in subsection (1)(b).

Sections 194, 195, and 196:

See Item C6-36.00.

POLICY

A. INTRODUCTION

The Board deducts applicable CPP disability benefits from the worker's permanent disability benefits where the injury occurs on or after June 30, 2002. Where a worker was injured before June 30, 2002 and the permanent disability first occurred on or after June 30, 2002, CPP disability benefits paid to the worker for the same injury will not be deducted from the worker's permanent disability benefits.

If a worker is paid CPP disability benefits for dependent children, the Board does not deduct CPP disability child benefits from the worker's permanent disability benefits.

B. CONFIRMATION OF CPP DISABILITY BENEFITS

The Board will advise a worker of the legislative requirement that CPP disability benefits be deducted from the worker's permanent disability benefits. To ensure that only the portion of CPP disability benefits related to the injury is deducted from the amount the Board pays for a worker's permanent disability, the Board needs information from the department continued under the *Department of Employment and Social Development Act* (Employment and Social Development Canada – "ESDC") confirming that the worker is receiving CPP disability benefits, the effective dates (start and end dates), the medical condition(s) for which CPP disability benefits are being paid, and the benefit amount. Workers are responsible for providing CPP information to the Board.

The worker's obligation to provide information to the Board to administer the claim is discussed in Item C12-93.20.

The Board will also advise a worker of the obligation to provide necessary CPP information and the consequences of failing to comply. If a worker fails to provide the necessary CPP information, the Board may reduce or suspend the worker's permanent disability periodic payments as discussed in Item C12-93.20.

C. DETERMINATION OF THE AMOUNT OF A CPP DISABILITY BENEFIT THAT IS ATTRIBUTED TO THE COMPENSABLE WORK INJURY

CPP disability benefit entitlement is based on total disablement which may encompass a work injury, other disabling conditions or a combination of both.

If a worker is disabled because of the work injury and there is evidence that leads the Board to determine that the disability benefits being issued under CPP are only related to the work injury, 50% of the entire CPP disability benefits paid to the worker will be deducted from the worker's permanent disability benefits payable by the Board.

If a worker is disabled because of the work injury and it is unclear what amount of CPP disability benefits is attributable to the compensable work injury, the amount of the CPP disability benefits attributable to the compensable work injury is determined as follows:

- If the permanent disability benefits are calculated under the section 195(1) method of assessment, the amount of the CPP disability benefits attributable to the injury is determined by using the same proportion to the total CPP disability benefits as the worker's assessed percentage of disability using the section 195(1) method. The Board deducts 50% of the calculated amount from the worker's permanent disability benefits payment.

- If the permanent disability benefits are calculated under the section 196(3) method of assessment, the amount of the CPP disability benefits attributable to the injury is determined by using the same proportion to the total CPP disability benefits as the worker's estimated loss of earnings bears to the worker's average net earnings. The Board deducts 50% of the calculated amount from the worker's permanent disability benefits payment.

If a worker is disabled because of the work injury and there is evidence that leads the Board to determine that the disability benefits being issued under CPP are not related to the injury, the Board will not deduct CPP disability benefits from the worker's permanent disability benefits.

D. DEDUCTION OF LUMP SUM PAYMENTS OF CPP DISABILITY BENEFITS

If the Board determines a worker's permanent disability benefit entitlement and the worker is later advised that the worker is entitled to CPP disability benefits and is paid a lump sum amount under the CPP, the Board will deduct 50% of the applicable CPP disability benefits paid to the worker from future benefit payment. The Board will, as far as possible, do this in a manner which causes the least hardship to the worker. Normally, the Board will recover the amount owing by installments.

E. DEDUCTION OF CPP DISABILITY BENEFITS IN CASES OF MINIMUM COMPENSATION

Benefits paid to a worker for a permanent disability are subject to a statutory minimum amount. CPP disability benefits will be deducted until the resulting permanent disability compensation amount falls to the statutory minimum.

If the amount to be paid for permanent disability is at or below the statutory minimum, the Board will not deduct CPP disability benefits.

EFFECTIVE DATE:	January 1, 2021
AUTHORITY:	Section 202 of the *Act*.
CROSS REFERENCES:	Item C12-93.20, *Obligation to Provide Information*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – Housekeeping change to update internal cross-references, consequential to reformatting and renumbering Chapter 12, *Claims Procedures*. January 1, 2021 – This policy resulted from the consolidation of former policy items #36.20, #36.21, #36.22, #36.23, and #36.24, consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

June 1, 2009 – Updated references to Human Resources and Skills Development Canada.

APPLICATION: Applies to all decisions, including appellate decisions, made on or after January 1, 2021.

RE: Permanent Total Disability Benefits **ITEM: C6-37.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on a worker's entitlement to permanent total disability benefits.

2. The Act

Section 194:

(1) Subject to subsection (2), if a permanent total disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the worker's average net earnings.

(2) Compensation to be paid under this section must not be less than $2 221.30 per month. *[Note: See Note on page 1 of the Act concerning dollar amount.]*

POLICY

A. INTRODUCTION

Section 194 of the *Act* pertains to the determination of a worker's entitlement to compensation for a permanent total disability that results from a work injury.

Some examples of permanent total disability are paraplegia, quadriplegia, hemiplegia, and total or near total blindness. Combinations of permanent partial disabilities can also become permanent total disabilities, such as bilateral amputations of arms and legs.

Permanent total disability periodic payments continue until a worker reaches age 65, or later if the Board is satisfied that the worker would work past age 65.
(See Item C6-41.00).

On reaching retirement age, a worker who has received permanent disability benefits is entitled to a retirement benefit (see Item C18-116.00). Permanently totally disabled workers are also entitled to rehabilitation benefits, health care benefits and personal

supports after reaching retirement age (Item C18-116.30). Board policies on the retirement benefit are contained in Chapter 18 of the *RS&CM*.

B. COMMENCEMENT OF PERMANENT TOTAL DISABILITY BENEFIT PAYMENTS

Permanent total disability benefits are granted as soon as the medical evidence confirms that the worker is permanently totally disabled as a result of the work injury or occupational disease.

However, it may be necessary to make this type of payment at a provisional rate under Item C9-65.10 pending clarification of the worker's pre-injury earnings.

After determining the amount of a worker's permanent total disability benefits, the Board must deduct from a worker's periodic payment, an amount that equals 50% of any Canada Pension Plan (CPP) disability benefit that the worker is paid in respect of the work injury. The required CPP disability benefit deduction is subject to the Board's statutory minimum (see Item C6-36.10).

C. MINIMUM AMOUNT OF COMPENSATION FOR PERMANENT TOTAL DISABILITY

Section 194(2) provides that the compensation to be paid for permanent total disability must not be less per month than the minimum set out below. This minimum is subject to cost of living adjustments as described in Item C7-51.00.

			$ Minimum
January 1, 2025	—	December 31, 2025	2,174.27
January 1, 2026	—	December 31, 2026	2,221.30

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

i. Statutory Minimum Application

The statutory minimum only applies in cases where the Board rates a worker's permanent disability at 100% under the section 195 method of permanent disability assessment. It does not apply when the percentage of permanent partial disability is less than 100% but the worker is found to be totally unemployable under the section 196 method of permanent disability assessment. (See Item C6-40.00).

D. REOPENING CLAIMS FOR A FURTHER PERIOD OF TEMPORARY DISABILITY

If a claim involving a permanent total disability is reopened, no payments of wage-loss benefits can be made. Wage-loss benefits may, however, be payable where a worker who is receiving permanent total disability benefits of less than the current maximum, incurs a new injury at work. The amount payable would be the difference between the permanent disability benefits periodic payment being paid on the old claim, and 90% of the long term average net earnings on the new claim, limited by the current maximum.

EFFECTIVE DATE:	January 1, 2021
AUTHORITY:	Sections 194 and 202 of the *Act*.
CROSS REFERENCES:	Item C6-36.10, *Canada Pension Plan Disability Benefits*; Item C6-40.00, *Section 196 Permanent Partial Disability Benefits*; Item C9-65.10, *Provisional Rate*; Chapter 18, *Retirement Benefits*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – Housekeeping change to update internal cross-reference, consequential to reformatting and renumbering Chapter 7, *Protection of and Deductions from Benefits*. July 4, 2025 – Housekeeping changes related to the reformatting and renumbering of Chapter 9, *Average Earnings*, of the *Rehabilitation Services & Claims Manual, Volume II*. January 1, 2021 – This policy resulted from the consolidation of former policy items #37.00, #37.10, #37.20, #37.21, and #37.30, consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits.* Amended to reflect amendment to retirement age determination provision of the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23). April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
APPLICATION:	Applies to all decisions made on or after January 1, 2021.

RE: Permanent Partial Disability Benefits **ITEM: C6-38.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on a worker's entitlement to permanent partial disability benefits.

2. The Act

Section 195:

(1) Subject to section 196, if a permanent partial disability results from a worker's injury, the Board must

(a) estimate the impairment of the worker's earning capacity from the nature and degree of the injury, and

(b) pay the worker compensation that is a periodic payment of an amount that equals 90% of the Board's estimate of the worker's loss of average net earnings resulting from the impairment.

(2) The minimum compensation to be paid under this section must be calculated in accordance with section 191(2) *[compensation for temporary total disability]* but to the extent only of the permanent partial disability.

(3) The Board may compile a rating schedule of percentages of impairment of earning capacity for specified injuries or mutilations that may be used as a guide in determining the compensation payable in permanent partial disability cases.

Section 196:

(1) This section applies in relation to a permanent partial disability if an amount required under section 195 is less than an amount required under this section.

(2) *Repealed*.

(3) The Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the difference between

(a) the average net earnings of the worker before the injury, and

(b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:

(i) the average net earnings that the worker is earning after the injury;

(ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury.

POLICY

Sections 195 and 196 of the *Act* pertain to the determination of a worker's entitlement to compensation for a permanent partial disability that results from a work injury.

In all cases where a permanent partial disability results from a work injury, a worker's entitlement to permanent partial disability benefits must be assessed using the methods set out in sections 195(1) and 196(3) of the *Act.*

If the amount assessed under section 195(1) is less than the amount assessed under section 196(3), the worker's permanent partial disability benefits will be determined under section 196(3).

Determination of a worker's entitlement to compensation under sections 195(1) and 196(3) is undertaken once a worker's condition has stabilized as permanent.

EFFECTIVE DATE:	January 1, 2021
AUTHORITY:	Sections 195 and 196 of the *Act*.
CROSS REFERENCES:	Item C6-39.00, *Section 195 Permanent Partial Disability Benefits*; Item C6-40.00, *Section 196 Permanent Partial Disability Benefits*; Chapter 14, *Changing Previous Decisions*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	January 1, 2021 – This policy resulted from the consolidation of former policy items #38.00 and #40.32, consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*. Policy changes consequential to implementing the permanent partial disability benefits provisions of the *Workers Compensation Amendment Act, 2020* (Bill 23). The principles set out in former policy item #40.32 are set out in Chapter 14, *Changing Previous Decisions*, of the *Rehabilitation Services & Claims Manual*, Volume II. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
APPLICATION:	Applies to all decisions, including appellate decisions, made on or after January 1, 2021.

RE: Section 195 Permanent Partial Disability Benefits ITEM: C6-39.00

BACKGROUND

1. Explanatory Notes

This policy provides guidance on assessing a worker's entitlement to permanent partial disability benefits under section 195 of the *Act*.

2. The Act

Section 195:

(1) Subject to section 196, if a permanent partial disability results from a worker's injury, the Board must

(a) estimate the impairment of the worker's earning capacity from the nature and degree of the injury, and

(b) pay the worker compensation that is a periodic payment of an amount that equals 90% of the Board's estimate of the worker's loss of average net earnings resulting from the impairment.

(2) The minimum compensation to be paid under this section must be calculated in accordance with section 191(2) *[compensation for temporary total disability]* but to the extent only of the permanent partial disability.

(3) The Board may compile a rating schedule of percentages of impairment of earning capacity for specified injuries or mutilations that may be used as a guide in determining the compensation payable in permanent partial disability cases.

POLICY

A. INTRODUCTION

Permanent partial disability benefits assessed under section 195(1), reflect the extent to which a particular injury is likely to impair a worker's ability to earn in the future.

Permanent partial disability benefits assessed under section 195(1) also reflect such factors as:

- short term fluctuations in the compensable condition;
- reduced prospects of promotion;
- restrictions in future employment;
- reduced capacity to compete in the labour market; and
- variations in the labour market.

In assessing a worker's entitlement to permanent partial disability benefits under section 195(1), the Board may make reference to section 195(3) of the *Act*. Section 195(3) of the *Act* provides:

> The Board may compile a rating schedule of percentages of impairment of earning capacity for specified injuries or mutilations that may be used as a guide in determining the compensation payable in permanent partial disability cases.

Once the percentage of disability is determined, it is applied to the worker's long term average net earnings, and the permanent partial disability benefits are 90% of the amount so determined.

Under the section 195(1) method of permanent partial disability assessment, a worker's percentage of disability is expressed as a percentage of total disability, with one hundred percent (100%) being the maximum possible rating for a totally disabled worker. A worker's percentage of permanent partial disability is based on the whole person. A worker, therefore, cannot be more than 100% disabled as a result of a work injury or combination of injuries.

B. DECISION-MAKING PROCEDURE UNDER SECTION 195(1)

Section 195(1) assessments are undertaken once a worker's condition has stabilized as permanent.

The Board is responsible for ensuring that the necessary examinations and other investigations are carried out with respect to the assessment and making a decision on a worker's entitlement to permanent partial disability benefits.

Section 195(1) evaluations may be conducted by the Board or a Board-authorized External Service Provider. The Board sets protocols and procedures for these evaluations. The Board determines whether the evaluation will be referred to an External Service Provider based on the nature of the condition and other relevant criteria as set out in the protocols. The Board may proceed to assess the permanent disability benefits without a section 195(1) evaluation if there is sufficient medical evidence already available.

C. PERMANENT DISABILITY EVALUATION SCHEDULE

Section 195(1) permanent disability benefits may be made with reference to the *Permanent Disability Evaluation Schedule* ("*Schedule*"), which is set out in Appendix 3. This is a rating schedule of percentages of disability for specific injuries or mutilations created under section 195(3).

The *Schedule* is a set of guide-rules, not a set of fixed rules. The Board is free to apply other variables in arriving at a final rating; but the "other variables" referred to means other variables relating to the degree of physical or psychological impairment, not other variables relating to social or economic factors, nor rules (including schedules and guide-rules) established in other jurisdictions. In particular, the actual or projected loss of earnings of a worker because of the disability is not a variable which can be considered. The Board's discretion to consider other variables is generally applied to address new and emerging conditions that are not already covered in the *Schedule*.

In cases where the specific impairment is not covered by the *Schedule*, but the part of the body in question is covered, the Board must first determine the percentage of loss of function in the damaged area. This determination is based on the findings of the section 195(1) evaluation and other medical and non-medical evidence available. The final rating is arrived at by taking this percentage of the percentage allocated in the *Schedule* to the disabled part of the body. Because the *Schedule* is used in the calculation, this type of permanent disability benefit is still considered as a Scheduled one. For example, the amputation of an arm down to the proximal third of the humerus or its disarticulation at the shoulder is given a 70% of total disability rating in the Schedule. Suppose a worker has a severe crush injury to the arm which culminates in a permanent loss of half its function. The final outcome would be 50% of 70%, i.e. a 35% of total disability rating.

D. NON-SCHEDULED RATING FOR PERMANENT DISABILITY BENEFITS

Any permanent disability benefits under section 195 where the *Schedule* is not directly or indirectly used in the assessment are non-Scheduled permanent disability benefits. This covers impairments in all parts of the body not listed in the *Schedule*. Disabilities resulting from multiple injuries or occupational diseases may also involve non-Scheduled permanent disability ratings. The rules governing respiratory and skin diseases are set out in the policy of Item C4-29.00 and Section A. of Item C4-32.00 respectively.

In the case of permanent disability benefits for non-Scheduled permanent disability ratings, judgment is used to arrive at a percentage of disability appropriate to the particular worker's impairment. Regard will be had to, among other things, the section 195(1) evaluation, the circumstances of the worker, medical opinions of Board or non-Board doctors, and to schedules used in other jurisdictions.

Neither the age adaptability or enhancement factors nor devaluation are formally applied in respect of non-Scheduled ratings for permanent disability benefits. However, in making a judgment as to the correct percentage of disability, the Board will have regard to the age of the worker, to existing disabilities in other parts of the worker's body, or to the combined effect of more than one disability in the same part of the body.

E. MINIMUM AMOUNT OF COMPENSATION FOR PERMANENT PARTIAL DISABILITY UNDER SECTION 195

Section 195(2) provides that the minimum compensation to be paid for permanent partial disabilities is calculated in the same manner as for temporary total disability but only to the extent of the permanent partial disability (see Section 2 of the policy in Item C5-33.10). Thus, for example, if a worker is injured on January 2, 1986, resulting in a residual disability assessed at 10% of total disability, the minimum compensation will be the lesser of 10% of $197.25 or 10% of the worker's average earnings prior to the injury.

The statutory minimum for permanent total disability under section 194 does not apply to permanent partial disability simply because a worker is found to be totally unemployable under section 196. (See Item C6-37.00.)

i. Injury Prior to January 1, 1965

Permanent partial disability benefits provided for injuries that occurred before January 1, 1965 are recalculated in accordance with the then minimum for permanent total disability but to the extent only of the partial disability. This minimum was an amount equal to $30.00 per week ($130.00 per month), unless the worker's average earnings were less, in which case compensation is paid in an amount equal to the average earnings.

Any increase resulting from the above provisions does not apply to commuted permanent disability benefits or the commuted portion of a worker's permanent disability benefits.

In considering whether the worker's earnings are less than the minimum, only the worker's actual earnings are relevant.

EFFECTIVE DATE: July 1, 2022
AUTHORITY: Section 195 of the *Act*.
CROSS REFERENCES: Item C5-33.10, *Wage-Loss Benefits For Temporary Total Disability*;
Item C6-37.00, *Permanent Total Disability Benefits*;
Item C6-40.00, *Section 196 Permanent Partial Disability Benefits*;

Appendix 3, *Permanent Disability Evaluation Schedule*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:

January 1, 2024 – Housekeeping change to update internal cross reference.
July 1, 2022 – Policy amended to remove procedures specific to determining permanent psychological disability benefits.
January 1, 2021 – This policy resulted from the consolidation of former policy items #39.00, #39.01, #39.10, #39.20, #39.30, and #39.31, consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*. Policy changes consequential to implementing the permanent partial disability benefits provisions of the *Workers Compensation Amendment Act, 2020* (Bill 23).
September 1, 2020 – Housekeeping change was made to correct a grammatical error and to add the title of Appendix 3 to the Cross Reference section.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
January 1, 2015 – Consequential amendments were made arising from changes to the *Permanent Disability Evaluation Schedule*.
June 1, 2009 – Removed references to Board officer, Rehabilitation and Compensation Services Division, Disability Awards Medical Advisor and Board authorized External Service Provider.
August 1, 2003 – Deletion of statements regarding revisions to the *Schedule* and housekeeping changes.

APPLICATION:

Applies to all decisions made on or after July 1, 2022.

RE: Chronic Pain **ITEM: C6-39.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on assessing a worker's entitlement to permanent partial disability benefits for chronic pain.

2. The Act

Sections 195 and 196:

See Item C6-38.00.

POLICY

A worker's entitlement to permanent partial disability benefits for chronic pain is considered under sections 195(1) and 196(3) of the *Act.*

Set out below are guidelines for the assessment of section 195(1) permanent partial disability benefits for workers who experience disproportionate disabling chronic pain as a compensable consequence of a physical or psychological work injury.

A. DEFINITIONS

Chronic pain is defined as pain that persists six months after an injury and beyond the usual recovery time of a comparable injury.

The Board distinguishes between two types of chronic pain symptoms:

Specific chronic pain - pain with clear medical causation or reason, such as pain that is associated with a permanent partial or total physical or psychological disability.

Non-specific chronic pain - pain that exists without clear medical causation or reason. Non-specific pain is pain that continues following the recovery of a work injury.

B. MULTIDISCIPLINARY ASSESSMENT

If a worker has been referred for a permanent partial disability assessment under section 195(1) for chronic pain, the Board may refer the worker for a multidisciplinary assessment. (See Item C3-22.20.)

A multidisciplinary assessment may involve consideration of the worker's medical history, health status, the impact of the pain on the worker's physical functioning, psychological state, behaviour, ability to perform the pre-injury occupation and ability to perform activities of daily living. (See Item C3-22.20.)

Based on the various assessments, the evaluation will provide the Board with information on whether the worker is experiencing persistent chronic pain as a result of a work injury or disease and the extent of the chronic pain. The evaluation will also provide information on the consistency of the worker's pain presentations.

C. EVIDENCE CONSIDERED IN A CHRONIC PAIN SECTION 195(1) ASSESSMENT

In making a determination under section 195(1), the Board will enquire carefully into all of the circumstances of a worker's chronic pain resulting from a compensable injury or disease.

The evidence that the Board may consider in a section 195(1) assessment for chronic pain includes the following:

- The findings of any multidisciplinary assessments.
- Information provided by the worker's attending physician as well as any other relevant medical information on the claim.
- The worker's own statements regarding the nature and extent of the pain.
- The worker's conduct and activities and whether they are consistent with the pain complaints.
- In cases of specific chronic pain, the Board will consider the extent of the associated physical or psychological permanent impairment and whether the specific chronic pain is in keeping with the particular permanent impairment.

The evidence that is relied upon to support the assessment of section 195(1) permanent disability benefits must be fully documented.

D. ENTITLEMENT TO PERMANENT DISABILITY BENEFITS UNDER A SECTION 195(1) ASSESSMENT

Entitlement to permanent disability benefits under section 195(1) for chronic pain may only be considered after all appropriate medical treatment and rehabilitation interventions have been concluded.

i. Specific Chronic Pain – Consistent with the Impairment

Pain is considered to be consistent with the associated compensable impairment where the pain is limited to the area of the impairment, or medical evidence indicates that the pain is an anticipated consequence of the physical or psychological impairment. In these cases, additional permanent disability benefits for the specific chronic pain will not be provided under section 195(1), as it would result in the worker being compensated twice for the impact of the pain.

ii. Specific and Non-Specific Chronic Pain – Disproportionate to the Impairment

A worker's entitlement to permanent disability benefits paid under section 195(1) for chronic pain will be considered in the following cases:

- If a worker experiences specific chronic pain that is disproportionate to the associated objective physical or psychological impairment.

  Pain is considered to be disproportionate if it is generalized rather than limited to the area of the impairment, or the extent of the pain is greater than that expected from the impairment.

  In these cases, permanent disability benefits for chronic pain under section 195(1) may be considered in addition to the permanent disability benefits paid for objective permanent impairment.

- If a worker experiences disproportionate non-specific chronic pain as a compensable consequence of a work injury or disease.

  Disproportionate pain, for the purposes of non-specific chronic pain, is pain that is significantly greater than what would be reasonably expected given the type and nature of injury or disease.

If the Board determines that a worker is entitled to permanent disability benefits for chronic pain under section 195(1) in the above noted situations, permanent disability benefits are assessed at 2.5% of total disability.

EFFECTIVE DATE:	January 1, 2021
AUTHORITY:	Sections 195 and 196 of the *Act*.
CROSS REFERENCES:	Item C3-22.20, *Compensable Consequences – Pain and Chronic Pain*; C6-39.00, *Section 195 Permanent Partial Disability Benefits*; C6-40.00, *Section 196 Permanent Partial Disability Benefits*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	January 1, 2021 – This policy replaces former policy item #39.02, consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*. Policy changes consequential to implementing the permanent partial disability benefits provisions of the *Workers Compensation Amendment Act, 2020* (Bill 23). April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted references to Board officers. January 1, 2003 – Amended to set out guidelines for the assessment of then section 23(1) awards for workers who experience disproportionate disabling chronic pain as a compensable consequence of a physical or psychological work injury. Amendments applied to new claims received and all active claims that were awaiting an initial adjudication on or after January 1, 2003.
APPLICATION:	Applies to all decisions, including appellate decisions, made on or after January 1, 2021.

RE: Section 196 Permanent Partial Disability Benefits ITEM: C6-40.00

BACKGROUND

1. Explanatory Notes

This policy provides guidance on assessing a worker's entitlement to permanent partial disability benefits under section 196 of the *Act*.

2. The Act

Section 196:

(1) This section applies in relation to a permanent partial disability if an amount required under section 195 is less than an amount required under this section.

(2) *Repealed*.

(3) The Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the difference between

(a) the average net earnings of the worker before the injury, and

(b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:

(i) the average net earnings that the worker is earning after the injury;

(ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury.

POLICY

A. INTRODUCTION

Permanent partial disability benefits assessed under section 196(3) reflect the worker's projected loss of earnings capacity, as determined by the Board.

Section 196(3) assessments are undertaken when the Board makes determinations under section 196(1).

B. SECTION 196(3) ASSESSMENT

The following apply when assessing a worker under section 196(3):

1. In determining the worker's projected loss of earnings capacity, the Board compares the average net earnings of the worker before the injury with the average net earnings the worker is earning after the injury or the average net earnings the Board estimates the worker is capable of earning in a suitable occupation after the injury.

2. Long term average net earnings the worker is earning after the injury will be determined in accordance with established policies in Chapter 9.

3. Average net earnings the Board estimates the worker is capable of earning in a suitable occupation after the injury will then be determined.

4. In estimating what a worker is capable of earning after the injury, the Board considers average net earnings that maximize the worker's long-term potential up to the worker's pre-injury wage rate selected from the occupations that are suitable and reasonably available over the long-term, as discussed in Section C below. Earnings in those occupations will be determined as at the time of the injury.

5. The Board compares the average net earnings the worker is actually earning after the injury with the estimated average net earnings of the selected suitable and reasonably available occupations, in order to determine the amount that best represents the worker's loss of earnings after the injury.

6. The calculation of the section 196 compensation amount will then be 90% of the average net amount by which the earnings level thus established is less than the average net earnings prior to the injury.

7. Any increase that may be due to the worker because of a cost of living adjustment will then be added.

8. Since the assessment under section 196(3) aims to predict the worker's actual loss of earnings over the future, no section 196 compensation can be paid when the worker is unemployed for reasons unrelated to the injury and it is determined that there will not be a potential loss of earnings.

C. SUITABLE OCCUPATION

In estimating what a worker is capable of earning in a suitable occupation after the injury, the Board considers the evidence, including the worker's individual circumstances, the limitations resulting from the compensable disability and pre-existing medical conditions, and the ability of the worker to perform different occupations.

Consideration is also given to the suitability of the worker for occupations that could reasonably become available over the long run that will maximize the worker's long-term earnings potential up to the pre-injury wage rate. In most cases, "long-term" refers to three to five years.

The Board assesses the suitability of an occupation and the worker's earning potential in light of transferable skills and all possible rehabilitation measures that may be of assistance, including the possibility of retraining or other measures that may be appropriate to the worker. (See Item C11-85.00.)

(i) Meaning of "suitable occupation"

An occupation differs from a "job", which is defined as a specific position with a particular employer. Occupation is a collection of jobs or employments that are characterized by a similarity of skills.

A suitable occupation

- is one for which the worker has the necessary skills, competencies, qualifications, and functional abilities, and is medically fit to undertake;
- does not impede the health and safety of the worker and/or others;
- maximizes the worker's long-term earnings potential to the pre-injury wage rate; and
- is reasonably available over the long term.

Pre-existing non-compensable factors, (including pre-existing medical conditions) will be considered when determining a suitable occupation. Non-compensable factors arising after the date of injury will generally not be considered when determining a suitable occupation.

(ii) Meaning of "reasonably available"

An occupation is considered reasonably available when the worker is competitively employable for a job or jobs within it, meaning the worker has a reasonable chance of securing employment in that occupation.

A reasonably available job is usually within a reasonable commuting distance of the worker's home. (See Item C11-88.90.)

If a suitable occupation is reasonably available over the long term, it is taken into consideration even though it is not available at the time of assessment because of general economic conditions.

If jobs in a suitable occupation are subject to fluctuations in the economy but a lower-paying job in another suitable occupation appears more stable in the long run, then the other job may be considered the best-paying job in the long run.

If the worker declines the best-paying job in the suitable occupation because of a personal preference for a lower-paying job or for a lifestyle choice which may impact earnings, the wage rate in the best-paying job in the suitable occupation will be used in the formula.

(iii) Assessing the worker's post-injury job

If the worker has made all reasonable efforts to maximize the worker's earnings, the job the worker has actually obtained is generally accepted as being suitable, unless there is evidence the job is transitory and jobs at another level of earnings within that occupation will be available to the worker in the near future.

The Board will generally only have regard to higher paying occupations which a person in the worker's present job would ordinarily be expected to obtain. It would not be fair to assume a worker will receive all possible advancements and wage increases that might theoretically be made available, as that approach could overestimate earnings.

D. MEASUREMENT OF EARNINGS LOSS

Subsections 196(3)(a) and (b) set out the process for determining a worker's entitlement to permanent partial disability benefits under this method. If permanent partial disability benefits are being paid under section 196, subsections 196(3)(a) and (b) provide that the Board must pay a worker compensation that is a periodic payment of an amount that equals 90% of the difference between the average net earnings of the worker before the injury, and either the average net earnings that the worker is earning, or that the Board estimates the worker is capable of earning, after the injury.

The latter figures are obtained by ascertaining the earnings in the occupations which have been found to be suitable and reasonably available according to the criteria set out in Section C of this Item and determining the earnings figure which will maximize the worker's long-term earnings potential.

A worker's post-injury earnings loss will be based on estimated earnings rather than on actual earnings in the following cases:

- The worker is employable but does not have a job; or
- The worker has a job but is not maximizing earning capacity up to the pre-injury rate;
- The worker has, for personal reasons, withdrawn from the workforce; or
- The worker does not cooperate with the rehabilitation process.

The intention of the *Act* is to protect workers' earnings only up to the maximum wage rate. This is shown by section 208(2), which results in payments for total disability being limited to 90% of the maximum and by section 200, which ensures that, where a worker is already receiving payments for a disability, additional payments can be made for any further disability only to the extent that they do not take the total payments above the maximum. No permanent partial disability benefits can be paid under section 196(3) where, following the injury, the worker is earning or is able to earn at or above the maximum wage rate. If a worker was earning at or above the maximum prior to the injury and it is projected that because of the injury, earnings will be less than the maximum, permanent disability benefits based on a projected loss of earnings can be paid but only to the extent of the difference between the maximum and the projected earnings.

Although assessment of permanent partial disability benefits will often be made some time after the original injury, it would not be fair to compare directly the actual pre-injury average earnings with the earnings the worker might now earn in the occupations available. The effect of inflation upon earnings levels would mean that the real loss would not be properly determined in that way.

The practice of the Board is to use the earnings in the occupations after the injury, as they stood at the date of the injury, where these are available and are a reliable and accurate reflection of the worker's post-injury earning capacity. For example, the Board may use actual earnings in post-injury occupations where earnings are the provincial minimum wage.

When earnings in occupations at the time of the injury are not available or are not a reliable and accurate reflection of the worker's post-injury earning capacity, the Board will use current earnings in the occupations available after the injury, and adjust them back to the date of injury by the wage inflation adjustment factors applicable in those years. The wage inflation adjustment factor is derived from the formula set out in section 209(2) of the *Act* to adjust the maximum wage rate. The wage inflation adjustment factor effective for a given year is the percentage change in:

- the annual average of wages and salaries in British Columbia for the year two years prior, from

- the annual average of wages and salaries in British Columbia for the year three years prior,

but not less than zero.

When calculating a worker's average net earnings for the purposes of the section 196(3) assessment, the Board will also consider the formulas used to determine the CPP contributions, EI premiums and income taxes applicable to the level of average earnings. The formulas used are those in effect in the calendar year preceding the date of the workers' injury.

E. PROVISION OF EMPLOYABILITY ASSESSMENTS

Where workers are provided with a copy of a completed employability assessment before a decision is made on entitlement to permanent disability benefits under section 196(3), they have 30 days in which to provide a written submission. All such submissions received within this time frame will be considered before the final decision is made. If the details of the employability assessment and its impact on the permanent disability benefits under section 196(3) are known and agreed to, the 30-day waiting period may be waived.

EFFECTIVE DATE: July 4, 2025

AUTHORITY: Section 196 of the *Act.*

CROSS REFERENCES:
Chapter 9, *Average Earnings*;
Item C11-85.00, *Vocational Rehabilitation – Principles and Goals;*
Item C11-88.90, *Vocational Rehabilitation – Relocation*;
Item C11-89.00, *Vocational Rehabilitation – Employability Assessments – Temporary Partial Disability and Permanent Partial Disability*;
Item C12-97.40, *Evidence – Other Matters*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:
July 4, 2025 – Policy amended to clarify the period of time used when calculating average net earnings under section 196(3), consequential to amendments to Item C9-71.00, and to reformatting and renumbering policies in Chapter 9, *Average Earnings,* of the *Rehabilitation Services & Claims Manual*, Volume II.
January 1, 2024 – Consequential changes to reflect language updates to Chapter 5, *Wage-Loss Benefits and Return to Work Obligations*.
November 23, 2022 – Policy clarified to confirm Board of Directors' intent that wage inflation adjustment factor is based on the change in the annual average of wages and salaries in British Columbia.
September 1, 2022 – Policy revised to clarify a worker's individual circumstances are considered when determining whether an occupation is suitable, and a reasonably available occupation is one for which the worker is competitively employable for a job or jobs within it.

January 1, 2021 – This policy resulted from the consolidation of former policy items #40.00, #40.01, #40.10, #40.12, #40.13, and #40.14, consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*. Policy changes consequential to implementing the permanent partial disability benefits provisions of the *Workers Compensation Amendment Act, 2020* (Bill 23).
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
April 1, 2018 – Policy revised to clarify when earnings are adjusted for inflation and to revise the factor used to account for inflation. Under this approach, the factor would be determined using the process for changing the maximum wage rate as set out in then subsections 33(7) – (10) (now sections 209 and 227) of the *Act.*
June 1, 2009 – Deleted references to Board officer, Medical Services and the former Disability Awards Committee.
March 3, 2003 – Inclusion of reference to review.
November 1, 2002 – Policy substantially revised. Clarified guidelines to be followed in determining suitable and reasonably available occupations for a worker. Amendments included the requirement of an employability assessment, and the limitation of "up to the worker's pre-injury wage rate".

APPLICATION: Applies to all decisions made on or after July 4, 2025.

RE: Duration of Permanent Disability Periodic Payments ITEM: C6-41.00

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the determination of a worker's retirement date for the purposes of the duration of permanent disability benefits decision under section 201 of the *Act*.

2. The Act

Section 201:

(1) Subject to subsection (2), periodic payment of compensation under this Division [Division 6 of Part 4 of the *Act* – Compensation for Worker Disability] may be paid to an injured worker only as follows:

(a) if the worker is under 63 years of age on the date of the injury, until the later of the following:

(i) the date the worker reaches 65 years of age;

(ii) if the Board is satisfied the worker would retire after reaching 65 years of age, the date the worker would retire, as determined by the Board;

(b) if the worker is 63 years of age or older on the date of the injury, until the later of the following:

(i) 2 years after the date of the injury;

(ii) if the Board is satisfied that the worker would retire after the date referred to in subparagraph (i), the date the worker would retire, as determined by the Board.

(2) As a restriction on subsection (1), the Board may not make a periodic payment to a worker under this Division if the worker ceases to have the disability for which the periodic payment is to be made.

(3) A determination made under subsection (1) (a) (ii) as to a date on which a worker would retire after reaching age 65 may be made after a worker has

reached age 63, and the Board may, when making the determination, consider the worker's circumstances at the time of that determination.

3. Workers Compensation Amendment Act, 2020 (Bill 23 of 2020)

Section 36:

A determination may be made under section 201(3) of the *Workers Compensation Act*, as added by section 18 of this Act, whether or not a determination has been made under section 201 (1) of that Act before the date section 18 of this Act comes into force [January 1, 2021].

POLICY

For the purpose of permanent disabilities, section 201(1) provides for the payment of permanent disability benefits:

- if a worker is under 63 years of age on the date of the injury, until the date the worker reaches 65 years of age, or
- if a worker is 63 years of age or older on the date of the injury, until two years after the date of the injury.

If the Board is satisfied a worker would retire after these dates, section 201(1) permits the Board to continue to pay permanent disability benefits to the date the worker would retire if the worker had not been injured.

For the purpose of this policy, a worker is generally considered to be retired when the worker substantially withdraws from the workforce and receives retirement income from one or more retirement-like sources (e.g., CPP, OAS, employer pension plan, RRSP or other personal savings).

A. EVIDENCE

As age 65 is the established retirement date under the *Act* if a worker is under age 63 on the date of injury, to continue to pay permanent disability benefits after the age of 65, the evidence must support a finding that the worker would work past age 65. Evidence is also required so that the Board can establish the worker's retirement date for the purposes of concluding permanent disability benefits payments. The standard of proof under section 339(3) is "at least as likely as not" as described by policy in Item C12-97.00. The gathering and weighing of evidence generally is covered by policy in Items C12-97.00 through C12-97.50.

The issue for the Board to determine is whether it is “at least as likely as not” that the worker would have retired after age 65 if the injury had not occurred. The Board considers the worker’s statement of intention to retire after age 65, but must determine whether it is “at least as likely as not” that the worker would have retired later than age 65. The Board may consider the worker's circumstances at the time of that determination. This means the Board may consider pre- and post-injury evidence to establish the date the worker would retire.

However, post-injury circumstances that happened only because of the injury are not relevant to determining when the worker would have retired if the injury had not occurred. Post-injury circumstances are relevant if they would have occurred even if the worker had not been injured.

When determining whether a worker would retire after age 65, the weight the Board gives to the types of evidence will vary with the circumstances of each claim. The following are examples of the kinds of evidence the Board may consider:

- names of the employer or employers, a description of the type of employment, the expected duration of employment, and information from the identified employer or employers to confirm their intention to employ the worker after the worker reached age 65 and that employment would be available;
- a statement from a bank or financial institution outlining a financial plan and post-age 65 retirement date;
- an accountant’s statement verifying a long-term business plan (for self-employed workers), indicating continuation of work beyond age 65;
- information provided from the worker’s employer, union or professional association regarding the normal retirement age for workers in the same occupation and whether there are incentive plans for workers working beyond age 65;
- information from the employer about whether the worker would be covered under a pension plan provided by the employer, and the terms of that plan;
- information from the employer or union on whether there was or is a collective agreement in place setting out the normal retirement age;
- information regarding whether the worker would have the capacity to perform the work;
- financial obligations of the worker, such as a mortgage or other debts;
- family commitments and/or circumstances of the worker; and

- an outstanding lease on a commercial vehicle (for self-employed workers).

This is not a conclusive list of the types of evidence that may be considered. The Board will consider any other relevant information in determining whether a worker would work past age 65 and at what date the worker would retire.

If a worker is 63 years of age or older on the date of the injury, the established retirement date under the Act is two years after the date of injury. In these cases, the issue for the Board to determine is whether it is "at least as likely as not" that the worker would have retired later than two years after the date of injury if the injury had not occurred. The Board applies the same evidentiary principles to this determination as for workers who are under age 63 at the date of injury. In particular, the Board may consider the worker's circumstances at the time of that determination, which means the Board may consider pre- and post-injury evidence to establish the date the worker would retire. Post-injury circumstances are relevant if they would have occurred even if the worker had not been injured.

B. WHEN DETERMINATION IS MADE

In most cases, the determination of a worker's retirement date is made as part of the decision regarding the duration of permanent disability benefits under section 201.

If a worker is under 63 years of age on the date of the injury, the decision on the duration of permanent disability benefits is generally made after the worker reaches age 63, but before reaching age 65. In some circumstances, the decision on the duration of permanent disability benefits may be made before the worker reaches age 63, if appropriate based on applicable law and policy, and the merits and justice of the case.

If a worker is 63 years of age or older on the date of the injury, the decision on the duration of the worker's permanent disability benefits is generally made as part of the decision on the worker's entitlement to permanent disability benefits.

The determination of a worker's retirement date may be made prior to the decision on the duration of permanent disability benefits, when the determination is made as part of a decision on the duration of the worker's wage-loss benefits. In these cases, the retirement date in the decision on the duration of wage-loss benefits will also apply to the resulting permanent disability benefits, if provided.

The determination of a worker's retirement date for the purposes of the duration of permanent disability benefits decision under section 201 is made once, unless section 36 of the *Workers Compensation Amendment Act, 2020*, applies. Under section 36, another determination may be made after the worker has reached age 63 if:

- the worker was under 63 years of age on the date of injury,

- a previous determination was made under section 201(1) before January 1, 2021, and

- the worker has not reached the date of retirement as previously determined by the Board.

C. WHEN PAYMENTS CONCLUDE

At the worker's date of retirement, as determined by the Board, periodic payments will conclude even if the worker's permanent disability remains.

In situations where a worker in receipt of permanent disability periodic payments dies from causes unrelated to the disability, the periodic payments will continue for the full month in which the death occurred. The effect of this policy will be that no overpayments will be considered to have arisen for the period from the date of the worker's death up to the end of the month covered by the last periodic payment.

If the worker dies prior to the commencement of payments for the permanent disability benefits, the compensation is calculated and paid to the date of death. The situation where such a worker would have received the permanent disability benefit as a lump sum payment is dealt with by policy in Item C6-45.00.

EFFECTIVE DATE:	February 1, 2026
AUTHORITY:	Section 201 of the *Act*.
CROSS REFERENCES:	Item C6-45.00, *Lump Sums and Commutations;* Item C7-48.10, *Overpayments/Money Owed to the Board*; Item C12-97.00, *Evidence – General;* Item C12-97.10, *Evidence Evenly Weighted;* Item C12-97.20, *Presumptions;* Item C12-97.30, *Medical Evidence;* Item C12-97.40, *Evidence – Other Matters;* Item C12-97.50, *Surveillance*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	February 1, 2026 − Amended to reference the general evidence policies and further clarify evidentiary principles for workers 63 and older at the date of injury. December 1, 2025 − Housekeeping change to update internal cross-reference, consequential to reformatting and renumbering Chapter 12, *Claims Procedures.* January 1, 2024 − Amended to revise the interpretation of "would retire" in section 201 and add additional guidance for workers 63 and older at the date of injury. January 1, 2021 − This policy replaces former policy item #41.00, consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*. Amended to reflect amendment to retirement age determination provision of the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23).

September 1, 2020 − Policy amended to clarify examples of evidence are parallel in then policy item #41.00 and then policy item #35.30 of the *Rehabilitation Services & Claims Manual*, Volume II.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
February 1, 2020 – Policy amended to provide guidance on legal issues of standard of proof, evidence, and causation.

APPLICATION: Applies to all decisions, including appellate decisions, made on or after February 1, 2026.

RE: Payment of Permanent Disability Benefits **ITEM: C6-42.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on how permanent disability benefits are paid.

2. The Act

Section 190:

> Compensation under this Division is subject to the following provisions:
>
> (a) section 230 *[manner of compensation payment: periodic or lump sum]*;
>
> (b) section 231 *[payment of compensation in specific circumstances]*;
>
> (c) section 232 *[Board authority to discontinue or suspend payments]*;
>
> (d) section 233 *[deduction in relation to payments from employer]*.

Sections 194, 195, and 196:

> See Item C6-36.00.

POLICY

A. INTRODUCTION

Although section 190 of the *Act* provides that all compensation for worker disability is subject to sections 230, 231, 232, and 233, permanent disability benefits under sections 194, 195 and 196 are normally payable monthly until the worker reaches retirement age as determined by the Board. However, some payments are made as lump sums. The cheques are mailed to the worker's home address or, if the worker elects, directly to the worker's bank by electronic direct bank deposit.

If a worker disagrees with the amount of permanent disability benefits and returns the cheque, or refuses to accept the cheque, the Board will not negotiate regarding the acceptance of the cheque. In such circumstances the worker is notified of the right to

request a review from the Review Division with regard to the matter on the claim to which there is an objection. This policy also applies to those cases where a worker has elected to receive the permanent disability benefit cheque by electronic direct bank deposit.

When a payment to a worker has been lost or stolen or otherwise not received or cashed by the worker, the worker may request a reissue of payment, but the Board will require a written and signed declaration of this from the worker before a reissue will take place.

B. COMMENCEMENT OF PERIODIC PAYMENTS

The general rule is that the permanent disability periodic payments commence at the date when the worker's temporary disability ceased and the worker's condition stabilized or was first considered to be permanent.

If a worker has been paid any wage-loss benefits under section 191 or 192 of the *Act*, the permanent disability periodic payments will take effect from the date following the termination of these wage-loss benefits. For the majority of cases, this will adequately reflect the financial impact of the disability on the worker's earnings.

There may, however, be the unusual situation where a worker has or could have returned to a significant level of employment with a minimal loss of income. Temporary partial disability wage-loss benefits under section 192 would be 90% of the worker's average net earnings in this employment. Should the worker's permanent disability benefits eventually be assessed at a higher rate than the rate paid for temporary wage-loss benefits under section 192, it would appear that the worker may have been inadequately compensated. The *Act*, however, precludes the payment of both temporary and permanent disability compensation for the same condition at the same time.

A problem of permanent disability benefits retroactivity also occurs when, although the worker had a temporary partial disability, the worker had or could have returned to full employment and has not, therefore, actually been paid any wage-loss benefits under section 192. As previously stated, the *Act* requires that the Board recognize a disability as either temporary or permanent, but not both concurrently. When carrying out the final permanent disability assessment, the Board will have the benefit of the earlier examination, or at least some other documentary evidence on file, on which the decision was made to delay permanent disability compensation. If the findings on the latter examination are the same as the initial findings, or only show a minimal degree of change, it is reasonable to consider the condition as having plateaued from the date of the first examination. In that event, the date of the first examination should be the starting date of the permanent disability periodic payments. If, on the other hand, the latest examination shows a measurable and significant change since the first examination, the worker will be considered as having been, in the interim, temporarily

disabled. In that event, the date of the last examination will be the starting date of the periodic payments for permanent disability benefits.

If there was no examination by either a Board Medical Advisor or an External Service Provider when wage-loss benefits were terminated under section 192, and there is no other measurable data on file with which to make a comparison with the final assessment of the Board, the permanent disability benefits will be backdated to the date wage-loss benefits were terminated under section 192.

C. RETROACTIVE PERMANENT DISABILITY BENEFITS

If permanent disability benefits are granted retroactively, the payments due prior to the date of the first periodic payment will be paid in the form of a lump sum.

In calculating that sum, entitlement in respect of a portion of a month is determined by reference to the actual calendar days in a particular month. For example, if a worker is entitled to permanent disability benefits calculated at $1,000 per month, for the period March 17 to 31 (15 calendar days), the calculation is as follows:

$$\frac{\$1{,}000}{31 \text{ days}} \times 15 \text{ days} = \$483.87$$

A reduction in the lump sum is made in respect of periods of time during the period following the commencement of the permanent disability benefits when the worker received wage-loss benefits under section 191 or 192 or vocational rehabilitation benefits under section 155. However, no such reduction is made when the permanent disability benefits are granted in the form of a lump sum and the monthly equivalent is less than $20.00 per month at the time of the commutation.

The payment of interest on the lump sum is dealt with in Item C7-50.00.

D. PERMANENT DISABILITY BENEFIT ADJUSTMENTS

If permanent disability benefits to a worker or a dependant are paid or increased on the basis of a Review Division decision, and the finding is later reversed by the Workers' Compensation Appeal Tribunal, the permanent disability payments are terminated or adjusted as of the date of the Workers' Compensation Appeal Tribunal decision. In such cases, the capitalization is adjusted by the reversal of an amount equivalent to the unused portion of the capitalization or, in the case of a modification, the adjustment applies to the amount of the capitalization affected by the modification. The policy regarding relief of costs to employers in such circumstances is detailed in Item C17-114.10.

EFFECTIVE DATE: January 1, 2024
AUTHORITY: Sections 190 and 230 of the *Act.*
CROSS REFERENCES: Item C17-114.10, *Investigation Costs*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY: December 1, 2025 – Housekeeping change to update internal cross-references, consequential to reformatting and renumbering Chapter 7, *Protection of and Deductions from Benefits* and Chapter 17, *Charging of Claim Costs.*
January 1, 2024 – Reorganization of policy direction from former policy item #34.60 into this Item, consequential to the reformatting and renumbering of policies in Chapter 5, *Wage-Loss Benefits and Return to Work Obligations*.
January 1, 2021 – This policy resulted from the consolidation of former policy items #42.00, #42.10, #42.12, and #42.20, consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
June 1, 2009 – Deleted references to Board officer.
March 3, 2003 – Amended regarding references to Review Division and Workers' Compensation Appeal Tribunal.
APPLICATION: Applies to all decisions made on or after January 1, 2024.

RE: Disfigurement Compensation **ITEM: C6-43.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on determining a worker's entitlement to compensation for permanent disfigurement under section 199 of the *Act*.

2. The Act

Section 199:

> If a worker experiences a serious and permanent disfigurement that the Board considers capable of impairing the worker's earning capacity, the Board may pay a lump sum in compensation and may do so even if the amount the worker was earning before the injury has not been reduced.

POLICY

A. REQUIREMENTS FOR DISFIGUREMENT COMPENSATION

Section 199 establishes the following requirements:

1. The disfigurement must be "permanent". A temporary disfigurement is not sufficient.

2. The disfigurement must be "serious". No permanent disfigurement compensation will be made if the disfigurement is minimal.

3. The disfigurement must be one that the Board considers capable of impairing the worker's earning capacity. This is normally assumed in cases of the head, neck and hands. In other cases, a decision must be made which considers the age and occupation of the worker, the visibility and extent of the disfigurement and any other relevant circumstances. Since section 199 states that the amount the worker is currently earning does not have to be reduced, this requirement is concerned with the worker's long-term earning capacity.

If there is disfigurement as well as a permanent disability, the worker may receive compensation for both. Subject to the Board applying section 230(2) of the *Act* (see Item C6-45.00), the compensation for the permanent disability is a periodic payment, and the compensation for disfigurement a lump sum. These amounts must be assessed separately.

Disfigurement is concerned with the appearance of the body, not loss of bodily function. Therefore, compensation for a loss of skin function, for example, soreness or itchiness or unusual sensitivity to light, heat or humidity, will be considered as a permanent disability rather than a disfigurement. The granting of permanent disability benefits will depend on the normal criteria for assessing permanent disability.

The ultimate aim of disfigurement compensation and permanent disability benefits is to pay for loss of earning capacity. The worker should not receive double compensation for the same loss. Compensation under section 199 is not granted for something which is directly covered by permanent disability benefits, for example, the deformity caused by the normal appearance of an amputated limb. Disfigurement compensation may be considered, where the appearance of an impairment for which permanent partial disability benefits have been granted, is disfiguring to an exceptional degree.

If the worker receives permanent disability benefits of 100% under section 195(1), or for total unemployability under section 196(3), there is no additional loss of earning capacity which can form the basis for disfigurement compensation under section 199.

If psychological disability results from disfigurement, consideration will be given to permanent disability benefits under section 195(1) or section 196(3) following the normal practices for such compensation (see Item C3-22.30).

B. AMOUNT OF DISFIGUREMENT COMPENSATION

In calculating the amount of compensation to pay for disfigurement, the guidelines set out below apply:

1. Points are assigned to each of five factors assessed individually according to the table set out below. The assessment will normally be based on photographs of the worker but there may also be a visual examination of the worker in exceptional cases. The Board will give reasons for the points assigned to each factor.

POINTS/FACTORS	0–24 POINTS	25–49 POINTS	50–74 POINTS	75–99 POINTS
Surface area of part of body **(see guideline 3)**	Less than 25%	25%–49%	50%–74%	75% or more
Texture and thickening **keloid scarring hardening**	Mild alteration of texture. Slight wrinkly, furrows or marks.	Moderate thickening. Moderate hardening. Mild dryness or scaling. Prone to pimples.	Major thickening. Major hardening. Moderate dryness or scaling. Frequent pimples. Prone to ulceration.	Severe. Severe. Major dryness or scaling. Frequent ulceration. Significant irregularity of scar.
Colour	Mild alteration of colour.	Moderate alteration of colour.	Major alteration of colour.	Severe alteration of colour.
Visibility	Less than 25% visible with work clothing.	25 to 49% visible with work clothing.	50 to 74% visible with work clothing.	75% visible or greater with work clothing.
Loss of bodily form	Mild depression or elevation.	Moderate depression or elevation.	Major depression or elevation. Moderate to major atrophy. Moderate to major irregularity of body.	Severe depression or elevation. Severe muscle or tissue loss.

2. An average is taken of the points assigned by dividing the total points by five. The result is rounded up to the nearest whole number. The disfigurement is then placed in one of four classes as follows:

Class 1	0 to 24 points
Class 2	25 to 49 points
Class 3	50 to 74 points
Class 4	75 to 99 points

3. The area of the body affected is determined. Five areas are recognized. A minimum and maximum amount of compensation exists for each of the

four classes for each area of the body including a dollar value per point within each class as shown in the following tables:

January 1, 2026 – December 31, 2026

Head and Neck

Class	Maximum Points	Minimum Compensation for Class ($)	Maximum Compensation for Class ($)	Dollar Value per point within Class ($)
1	24	0	8,626.80	359.45
2	49	8,971.86	17,253.30	345.06
3	74	18,659.38	52,405.30	1,406.08
4	99	53,802.77	87,342.05	1,397.47

Each Hand

Class	Maximum Points	Minimum Compensation for Class ($)	Maximum Compensation for Class ($)	Dollar Value per point within Class ($)
1	24	0	2,803.68	116.82
2	49	2,924.45	5,822.93	120.77
3	74	6,280.12	17,252.68	457.19
4	99	17,727.12	29,113.68	474.44

Each Arm

Class	Maximum Points	Minimum Compensation for Class ($)	Maximum Compensation for Class ($)	Dollar Value per point within Class ($)
1	24	0	2,156.64	89.86
2	49	2,242.90	4,313.14	86.26
3	74	4,666.80	13,154.64	353.66
4	99	13,499.70	21,781.14	345.06

Each Leg (including the foot)

Class	Maximum Points	Minimum Compensation for Class ($)	Maximum Compensation for Class ($)	Dollar Value per point within Class ($)
1	24	0	1,509.12	62.88
2	49	1,560.88	2,803.12	51.76
3	74	3,036.05	8,626.37	232.93
4	99	8,857.38	14,401.62	231.01

Torso

Class	Maximum Points	Minimum Compensation for Class ($)	Maximum Compensation for Class ($)	Dollar Value per point within Class ($)
1	24	0	1,509.12	62.88
2	49	1,560.88	2,803.12	51.76
3	74	3,036.05	8,626.37	232.93
4	99	8,857.38	14,401.62	231.01

The dollar values per point within each class are adjusted on January 1 of each year. The minimum and maximum amount of compensation for each class is adjusted accordingly. Since June 30, 2002, the percentage change in the consumer price index determined under section 333 of the *Act*, as described in Item C7-51.00 will be used.

4. The amount of the compensation in Class 1 is obtained by multiplying the average criterion score for disfigurement by the dollar value per point within the class. For example, if the average criterion score for a hand disfigurement is 6, it is assigned to Class 1 of the hands area of the body and the amount of the compensation is $700.92 (6 x $116.82).

5. The amount of the compensation for a disfigurement in Classes 2, 3 or 4 is obtained by subtracting the maximum points in the previous class from the average criterion score for disfigurement. Next, the total is multiplied by the dollar value per point within the class, followed by adding to the total, the maximum amount of compensation in the previous class. For

example, if a burn to the chest is assigned an average criterion score of 34, it is in Class 2 of the torso area of the body and the amount of the compensation is $2,026.72 [(34 – 24) x $51.76 + $1,509.12].

Detailed examples of the application of the above guidelines are set out below:

Example 1

The worker has a loss of the fingernail and nailbed, slight shortening of the right mid finger, a small curved raised nail growing through the graft at the injury site. Assuming that the disfigurement was found capable of impairing earning capacity, the compensation amount would be calculated as follows:

Factors	Description	Points
Surface area	Less than 25%	2
Texture / keloid	Minimal alteration; no keloid	2
Colour	No contrast	0
Visibility	Less than 25%	20
Structure	Mild evidence of depression	5

A. Total points are 29.

B. Average criterion score is 6 (29/5). Disfigurement is in Class 1.

C. Multiply the average criterion score for the hand disfigurement by the dollar value per point within Class 1 = $700.92 (6 x $116.82).

Compensation amount is $700.92.

Example 2

The worker has healed burns that extend up the right side and front of the abdomen and chest. There is evidence of occasional ulceration and moderate irregularity of the scars. Scar colour is significantly different when compared to unaffected skin. Assuming that the disfigurement was found capable of impairing earning capacity, the compensation amount would be calculated as follows:

Factors	Description	Points
Surface area	Less than 25%	20
Texture / keloid	Some puckering and contraction moderate keloid, scars raised to 3 mm	70
Colour	Significant contrast	80
Visibility	Nil	0
Structure	No evidence of depression or elevation other than keloid	0

A. Total points are 170.

B. Average criterion score is 34 (170/5). Disfigurement is in Class 2.

C. The maximum points for a torso disfigurement in the previous class (Class 1) subtracted from the average criterion score for the torso disfigurement is 10 (34 – 24).

D. The total from line C multiplied by the dollar value per point within Class 2 for a torso disfigurement, followed by adding to the total, the maximum compensation for a torso disfigurement in the previous Class (Class 1) is $2,026.72 [(34 – 24) x $51.76 + $1,509.12].

Compensation amount is $2,026.72.

EFFECTIVE DATE: January 1, 2021
AUTHORITY: Section 199 of the *Act.*
HISTORY: December 1, 2025 – Housekeeping change to update internal cross-reference, consequential to reformatting and renumbering Chapter 7, *Protection of and Deductions from Benefits*.

January 1, 2021 – This policy resulted from the consolidation of former policy items #43.00, #43.10, and #43.20, consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
June 1, 2009 – Deleted reference to Board officer.
May 1, 2008 – Amendments to the formula for determining the amount of disfigurement compensation to ensure that disfigurement payments increase uniformly within each class for greater degrees of disfigurement. Applied to all decisions including appellate decisions made on or after May 1, 2008.

APPLICATION: Applies to all decisions, including appellate decisions, made on or after January 1, 2021.

RE: Proportionate Entitlement **ITEM: C6-44.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on when proportionate entitlement under section 146 of the *Act* applies.

2. The Act

Section 146:

> The following apply to compensation under this Part in relation to personal injury or disease that is superimposed on an already existing disability:
>
> (a) the compensation is limited to the proportion of the disability following the injury or disease that may reasonably be attributed to that injury or disease;
>
> (b) the measure of the disability attributable to the injury or disease must, unless it is otherwise shown, be the difference between the extent of the worker's disability before and disability after the occurrence of the injury or disease.

POLICY

Section 146 deals with cases where the compensability of the immediate injury and disability has been accepted by the Board. It does not concern itself with the initial adjudication as to the causation of the particular disability.

A. MEANING OF ALREADY EXISTING DISABILITY

The mere fact that the worker had some weakness, condition, disease, or vulnerability which partially caused the personal injury or disease is not sufficient to bring Proportionate Entitlement into operation. The pre-existing condition must have amounted to a disability prior to the occurrence of the injury or disease.

Three situations are distinguished:

1. In cases where it has been decided that the precipitating event or activity, and its immediate consequences, were so severe that the worker's present disability would have resulted in any event, regardless of any pre-existing disability, section 146 should not be applied.

2. In cases where the precipitating event or activity, and its immediate consequences, were of a moderate or minor significance, and where there is only x-ray evidence and nothing else showing a moderate or advanced pre-existing condition or disease, Proportionate Entitlement should not be applied. These cases should not be classified as a disability where there are no indications of a previously reduced capacity to work and/or where there are no indications that prior ongoing medical treatment had been requested and rendered for that apparent disability. In determining whether there has been ongoing treatment, the Board considers the frequency of past treatments and how long before the injury they occurred.

3. Where the precipitating event or activity, and its immediate consequences, were of moderate or minor significance, but x-ray or other medical evidence shows a moderate to advanced pre-existing condition or disease, and there is also evidence of a previously reduced capacity to work and/or evidence of a request for and rendering of medical attention for that disability, section 146 should be applied.

Section 146 only applies where an injury is "superimposed" on an already existing disability. The injury and the existing disability must be in the same part of the body.

The fact that the worker has a payment from another agency for a pre-existing disability does not affect the Board's practice. The Board makes its own assessment of the pre-existing disability and is not bound by the percentage determined by the other agency.

B. WAGE-LOSS BENEFITS AND HEALTH CARE BENEFITS

It is not the policy of the Board to apply the provisions of section 146 to health care benefits or wage-loss benefits. The Board pays wage-loss benefits on the simple presumption that the worker was fit and able to carry on regular duties prior to the injury and is, at the time of receiving wage-loss benefits, totally or partially unable. The only conclusion to be derived from these facts is that the injury itself is the sole cause of that immediate total or partial disability. Proportionate Entitlement is thus a concept applicable only to permanent disability benefits.

C. PERMANENT DISABILITY BENEFITS

If a worker already has a pre-existing disability, and a work injury results in an aggravation of the disability, wage-loss benefits are paid for the period of any temporary total disability. If the aggravation was temporary only and the worker recovers from the aggravation so that the worker is restored to the position of the pre-existing disability, there is then no residual permanent disability resulting from the work injury, and therefore no further compensation. However, if a pre-existing disability is permanently aggravated by the work injury, and the worker's condition has stabilized, the Board must then consider how much of the condition is the compensable aggravation.

Assuming that a pre-existing impairment has been established, section 146 states that compensation is limited to the proportion of the "disability" following the injury or disease that may reasonably be attributed to that work-related injury or disease. "Disability" means loss of body function or physical impairment.

Under section 146, the measure of the permanent disability attributable to the work injury or disease must, unless it is otherwise shown, be the difference between the extent of the worker's disability before and disability after the occurrence of the injury or disease.

The Board's practice in relation to section 146 has no relevance to conditions which arise after the injury. It is only concerned with pre-existing problems. The Board's practice is that it will apportion its responsibility in respect of a permanent disability attributable to causes other than the work injury arising after the injury.

Consider the example of a worker whose average net earnings are $1,000 per month and who, following a work injury, has a 10% permanent disability. If the whole of that disability is attributable to the injury, the monthly permanent disability benefits paid under section 195 is 90% of 10% of $1,000, i.e. $90.00 a month. If, however, 3% out of the total impairment existed prior to the injury, section 146 requires that permanent disability compensation only be paid in respect of the 7% caused by the injury. The worker would therefore receive 90% of 7% of $1,000 per month, i.e. $63.00.

D. APPLICATION OF PROPORTIONATE ENTITLEMENT

In every case where there was a pre-existing disability, the Board has to decide whether the loss of earnings experienced by the worker after the injury is wholly the result of the compensable disability or partly the result of the pre-existing disability. If it decides that the whole loss is the result of the compensable disability, no reduction in the permanent disability benefits is made under section 146. If it decides that a portion of the loss is attributable to the pre-existing disability, the permanent disability benefits are only paid for the portion attributable to the compensable disability.

The Board feels that this is fair to workers in that it allows for the fact that their pre-injury earnings may already have been reduced by the pre-existing disability. On the other hand, it ensures that the Board does not become responsible for loss of earnings which are really attributable to the delayed or progressive effect of non-compensable pre-existing disabilities. The Board recognizes that it is often difficult in practice to properly allocate the causes of a loss of earnings where there is pre-existing disability, but does not feel that it is any more difficult than other decisions that have to be made under the *Act*, or that this difficulty justifies a different interpretation of section 146.

EFFECTIVE DATE:	January 1, 2021
AUTHORITY:	Section 146 of the *Act*.
HISTORY:	January 1, 2021 – This policy resulted from the consolidation of former policy items #44.00, #44.10, #44.20, #44.30, and #44.31, consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
APPLICATION:	Applies to all decisions, including appellate decisions, made on or after January 1, 2021.

RE: Lump Sums and Commutations **ITEM: C6-45.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on a worker's entitlement to lump sums and/or commutations of permanent disability benefits.

2. The Act

Section 120:

(1) The following apply to an amount payable as compensation or by way of commutation of a periodic payment in respect of compensation:

(a) the amount is not capable of being assigned, charged or attached;

(b) the amount must not pass by operation of law except to a personal representative.

(2) A claim must not be set off against an amount referred to in subsection (1), except for money

(a) advanced by way of financial or other social welfare assistance owing to the government, or

(b) owing to the accident fund.

Section 204:

(1) This section applies to a worker who is receiving periodic payments under section 194(1), 195(1) or 196(3) *[compensation for permanent disability]*.

(2) The Board must set aside, at the time a periodic payment is made to a worker, an amount that

(a) equals 5% of the periodic payment, and

(b) is in addition to the periodic payment.

(3) The Board must provide each worker with an annual statement containing all relevant information about the funds accumulated by the Board for payment of the worker's retirement benefit.

Section 230:

(1) Subject to this section, payments of compensation under this Part must be made periodically at the times and in the manner and form the Board considers advisable.

(2) The Board may, at the Board's discretion, do the following:

(a) commute all or part of

(i) the periodic payments due or payable to a worker or dependant, and

(ii) the future amounts that are to be set aside for payment of a retirement benefit,

to one or more lump sum payments, to be applied as directed by the Board;

(b) divide into periodic payments compensation that is otherwise payable as a lump sum.

(3) In the case of a worker's

(a) death,

(b) permanent total disability, or

(c) permanent partial disability where the impairment of the earning capacity of the worker is greater than 10% of the worker's earning capacity at the time of the injury,

commutation of periodic payments must not be made under subsection (2) except on the application of and at an amount agreed to by the worker or dependant entitled to the payments.

Sections 194, 195, and 196:

See Item C6-36.00.

POLICY

A. PERMANENT DISABILITY PERIODIC PAYMENT CATEGORIES/LUMP SUM PAYMENTS

Category A:

In the case of a worker's permanent partial disability, where the worker's

1. compensable disability has been assessed under section 195(1) at not greater than 10% of total disability, and

2. the permanent disability periodic payment is not more than $350.00 per month,

a lump sum will be paid in lieu of a monthly permanent disability periodic payment and the additional future amounts to be set aside by the Board for the payment of a retirement benefit under section 204 of the *Act*.

Category B:

In any case not within Category A, where the permanent disability periodic payment is more than $350.00 per month, the compensation will consist of a monthly permanent disability periodic payment and the additional future amounts to be set aside by the Board for the payment of a retirement benefit. A commutation will only be considered under the circumstances outlined below.

With the exception of the retirement benefit provision, this policy applies similarly to periodic payments of compensation made to a dependant of a deceased worker.

If a worker is receiving benefits for more than one permanent disability or a dependant is receiving compensation on more than one claim, the above figures apply to the combined total. If the worker or dependant has had previous commutations or lump sum payments, these previous payments are not applied to the combined total.

If a commutation request is made after the payment has begun on permanent disability benefits or a dependant benefit, the monetary level at the date of the request is used rather than the level at the effective date of the compensation.

B. CRITERIA FOR ALLOWING OR DISALLOWING A COMMUTATION

The same criteria apply, whether or not the Board has recovered all or part of the capital reserve in a third party action.

Workers provided compensation that falls within Category A will automatically be given a lump sum payment.

The general rule is that no commutation will be provided for cases in Category B.

There are, however, certain situations where a commutation may be desirable. The purpose of the guidelines set out below is to define those situations where it is in the worker's long term interests to receive a commutation and to state the terms and conditions on which such commutations are granted.

In considering a commutation, the following will apply:

1. A commutation must be for a specific purpose.

2. A commutation will, in general, only be allowed for purposes that are calculated to enhance the income position of the worker.

3. The applicant must have a stable source of income other than the permanent disability benefits.

4. A commutation will not be allowed where the applicant has demonstrated an inability to sustainably manage their finances.

5. Where there is an application by a surviving spouse to commute compensation that is paid in whole or part for dependent children, the Board considers the separate interests of the dependent children.

6. If the other requirements are met, a commutation may be in the worker's long-term interests, notwithstanding the worker's medical condition may not have settled or involves a significant risk of deterioration. However, while a potential deterioration in the worker's condition will not automatically bar a request, it is a relevant factor to be considered. It might, for instance, lead to a conclusion that the worker's existing income from other sources would not be stable from a long-term point of view.

   Similarly, the fact that a disability may improve in the future will not automatically bar a request for a commutation, even though the commutation will prevent the Board from reducing the amount of the permanent disability benefits when the improvement occurs. The possibility of such an improvement may, however, be taken into account if it is significant. It may influence the amount of commutation granted.

7. A short expectation of life or a worker's wish to benefit dependants following the worker's death is not a ground on which the Board can permit a commutation.

C. DEATH OF WORKER PRIOR TO PAYMENT UNDER CATEGORY A

The *Act* distinguishes between two different categories of benefits:

1. Benefits payable to a worker with a disability.

2. Benefits payable to dependants and others in respect of the death of a worker.

Under the terms of the *Act*, permanent disability benefits are payable to a living worker. There is no provision for permanent disability benefits to be payable in respect of a deceased worker. This includes permanent disability compensation paid as a lump sum.

If a worker dies before a Category A lump sum payment has been issued, the lump sum payment will be cancelled and the permanent disability benefits will be recalculated up to the date of the worker's death.

D. TYPES OF COMMUTATIONS PERMITTED

Where a partial or full commutation of permanent disability benefits is granted, the corresponding portion of the future amounts that are to be set aside for payment of a retirement benefit will also be commuted.

Any amounts that have already been set aside by the Board in the retirement reserve will be held in the reserve until the worker reaches retirement age. These amounts will not be commuted.

There are two types of commutations that the Board may permit:

1. A partial commutation resulting in a reduced level of both the permanent disability periodic payments, and corresponding retirement benefits set aside by the Board.

2. A full commutation of both the permanent disability benefits, and corresponding retirement benefits set aside by the Board.

   With the exception of the retirement benefit provisions, the Board permits the same types of commutations of periodic payments of compensation made to a dependant of a deceased worker.

To ensure that a commutation is used for the purpose for which it is sought, the Board may make a commutation cheque payable to a worker and to another person.

E. PURPOSE OF COMMUTATIONS

Certain purposes for which commutations are commonly requested are discussed below. The list is not intended to cover every purpose for which a commutation may be requested but rather is designed to provide guidelines to ensure the consistent handling of certain common types of application.

i. Paying Off Debts

The Board is concerned that lenders might be encouraged to grant excessive extensions of credit to workers in receipt of permanent disability benefits if they became aware that commutations could easily be obtained to pay off debts. Section 120 of the *Act* seeks to protect workers from creditors by making permanent disability periodic payments non-assignable. The Board will not undermine this intention by freely allowing commutations for the purpose of debt reduction.

A person incurring heavy debt may have serious long-term problems which will not be resolved simply by a commutation to pay debts. These problems may lead to incurring further debt even if the existing debt is paid. The person will then be in an even more serious position than before because there will now be no permanent disability periodic payments. The Board considers whether the applicant has thoroughly explored other alternatives before allowing commutation applications for this purpose.

ii. Investments

A commutation will not be allowed for investment purposes.

iii. Starting a Business

From a purely financial standpoint, it may be difficult to distinguish between investing in one's own business and other forms of investment. It is, moreover, often difficult for officers of the Board to determine with any degree of certainty whether what the worker wishes to undertake is a sound business venture.

Investing in one's own business, however, may be in the worker's best interests where there is a strong element of rehabilitation involved and the worker will be an active participant in operating the business. Any application for a commutation for the purpose of starting a business will be thoroughly investigated with these considerations in mind.

In each case where a business start-up is contemplated for which a commutation has been requested, or as a vocational rehabilitation measure, the Board will obtain, with the worker's written consent, an appraisal of the viability of the proposed business from

the Business Development Bank of Canada or some similar organization before a final decision on the commutation request, or rehabilitation measure, is made.

iv. Education

Unless the proposed educational program will promote the worker's career, a commutation for this purpose would not normally enhance the worker's income position and consequently would not satisfy the above general guidelines. There may, however, be some therapeutic benefit in allowing workers to improve their education when the improvement cannot be provided through normal rehabilitation programs. The requirement for the applicant to have a stable source of income may be waived where the Board is satisfied that the training or educational program will increase the prospects of employment and therefore enhance the income position over the long term. Where the program will not increase the employment prospects, but will have a significant therapeutic benefit, the Board may waive the requirement that the commutation be for a purpose that enhances the worker's income position. In such a case, it will not waive the requirement that the applicant have a stable source of income.

v. Buying a Home

Commutations for purchasing a home will be allowed under the following conditions:

1. The home is purchased as a personal residence.

2. The worker will obtain clear title to the property subject only to any mortgage.

3. Any mortgage payments are well within the worker's ability to pay from other income.

4. The size, value and upkeep costs of the home are in line with other income.

The discharge or reduction of an existing mortgage will be dealt with under the criteria for paying off debts in Section i, rather than under the criteria for buying a home. In administering this feature, however, a request for a commutation to discharge or reduce an existing mortgage should primarily be considered in the same general vein as a commutation to purchase a home, with the added insurance that consideration should be given to the safeguards built into the debt payment provisions. The expectation of this approach is that, in general, given similar circumstances, there should be little difference in the result following a decision made under either category. A commutation for the purpose of extending an existing home may be allowed if the above requirements are satisfied.

A commutation will not normally be allowed for the purpose of purchasing a second home to be used for vacations, or retirement, or to be rented out. The home must be for the purpose of providing the applicant with current accommodation.

F. DECISION-MAKING PROCEDURES

The Board is responsible for investigating an application for a commutation and making a decision on the application. Vocational rehabilitation input may be obtained before making a decision.

Where a commutation application is under consideration, the value of the proposed commutation can be made available so that the applicant may properly evaluate the options open.

G. AMOUNT PAID ON COMMUTATIONS

When a permanent disability benefits reserve and retirement benefits reserve are established or a liability is calculated for permanent disability benefits and a retirement benefit, the monthly permanent disability benefits payment amount and the periodic future retirement benefits amounts to be set aside by the Board for the payment of a retirement benefit, are converted to a lump sum by applying an actuarial net discount rate. This provision also applies if a reserve is established or a liability is calculated for periodic payments of compensation made to a dependant of a deceased worker. The actuarial net discount rate is set by the Board and represents the anticipated difference between long term future investment returns and long term future inflation.

Similarly, when the Board commutes permanent disability benefits, the monthly permanent disability payment amount and the periodic amounts set aside by the Board for a retirement benefit are converted to a lump sum by applying a commutation net discount rate. For Category A benefits: permanent disability benefits and the future amounts to be set aside by the Board for the payment of a retirement benefit that are automatically commuted by the Board without a request from the worker; the commutation net discount rate used will be equal to the actuarial net discount rate. For all others: permanent disability benefits and the future amounts to be set aside by the Board for the payment of a retirement benefit that are commuted by the Board at the worker's request, the commutation net discount rate used will be equal to the actuarial net discount rate increased by .5 percentage points. The increased net discount rate also applies to a commutation granted by the Board for dependant benefits at the dependant's request.

i. Calculation of Lump-Sum Payment or Commutation

Where, as a result of the application of this policy, the Board decides on a lump sum or commutation, it is paid forthwith.

Whenever a lump-sum payment or commutation is calculated following the review or appeal process, the calculation will be based on the date on which it is processed.

EFFECTIVE DATE:	February 1, 2026
AUTHORITY:	Sections 120, 204, and 230 of the *Act.*
CROSS REFERENCES:	Item C11-88.60, *Vocational Rehabilitation – Business Start-ups*; Chapter 18, *Retirement Benefits*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	February 1, 2026 – Amended to increase the monetary threshold for automatic commutations and update language. January 1, 2021 – This policy resulted from the consolidation of former policy items #45.00, #45.10, #45.20, #45.21, #45.30, #45.40, #45.41, #45.42, #45.43, #45.44, #45.45, #45.50, #45.60, and #45.61, consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. November 24, 2011 – Housekeeping amendments made in accordance with legislative amendments to the then *Act*. June 1, 2009 – Deleted references to Board officers, Vocational Rehabilitation Services and Compensation Services Division. April 8, 2003 – Amended to state that whenever a lump sum payment or commutation is calculated following the review or appeal process, the calculation will be based on the date on which it is processed. October 1, 2002 – Changes were made to the threshold amounts for automatic commutations and the criteria for considering commutations were broadened. Please refer to BOD Decision No. 2002/08/27-04 for details of the amendments. The policy as amended apply to all new claims received, all active claims that were awaiting an initial adjudication on permanent disability award adjudication, and all active claims that were awaiting initial adjudication of periodic payments of compensation to a dependant of a deceased worker, on or after October 1, 2002. Reference to a 1975 claim decision deleted. Policy revised to provide that where future benefits have been issued after the death of a worker, the benefit will be cancelled and recalculated up to the date of the worker's death. Changes made pursuant to BOD Decision No. 2002/08/27-04 did not apply to workers in receipt of a permanent disability award based on a projected loss of earnings that was initially adjudicated before October 1, 2002. July 16, 2002 – This policy was created to apply to all decisions made on or after July 16, 2002 in respect of injuries occurring on or after June 30, 2002, permanent disabilities where the permanent disability first occurred on or after June 30, 2002, and recurrences where the recurrence occurs on or after June 30, 2002, irrespective of the date of injury.
APPLICATION:	Applies to all decisions made on or after February 1, 2026.

RE:	Reconsideration of Prescribed Compensation Claims under Section 203	ITEM:	C6-46.00

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the reconsideration of prescribed compensation claims under section 203 of the *Act*.

2. The Act

Section 203:

(1) This section applies to claims for compensation that the Board may, by regulation, determine.

(2) A worker may apply for reconsideration of compensation payable to the worker if

(a) the worker's claim is of a type prescribed under subsection (1),

(b) the worker continues to have a compensable disability that was sustained more than 10 years before the worker's application under this section is made, and

(c) either

(i) the permanent disability compensation determined by the Board for the worker was based on a percentage of total disability of 12% or greater, or

(ii) the worker's case is of a kind in which the Board uses a projected loss of earnings method in calculating the compensation.

(3) A worker may apply under this section even though the worker has received

(a) compensation for permanent disability that has been wholly or partly commuted under section 230 *[commutation of periodic payments to lump sum payment]*, or

(b) compensation for a fixed term,

but, for the purposes of this section, the worker is deemed to be still receiving the periodic payments that have been commuted or the life equivalent of the periodic payments made for a fixed term.

(4) Despite section 122(1) *[Board decisions are final]*, if a worker's application under this section is with respect to a claim for compensation to which this section applies,

(a) the Board must reconsider the compensation provided to the worker, and

(b) if, having regard to the projected loss of income resulting from the worker's disability, the Board considers that the worker is not receiving adequate compensation, the Board must increase or establish periodic payments accordingly.

(5) For the purposes of subsection (4), the Board must consider compensation to be adequate if,

(a) in the case of a worker who is under 65 years of age, the amount of compensation provided to the worker is at least 75% of the projected loss of earnings resulting from the worker's disability, and

(b) in the case of a worker who is 65 years of age or older, the amount of compensation provided to the worker is at least 75% of the projected loss of retirement income resulting from the worker's disability.

(6) Periodic payments increased or established under this section for a worker who is under 65 years of age are subject to readjustment, by reference to subsection (5)(b), on the worker reaching 65 years of age.

(7) The calculation of compensation under this section must be made in the manner the Board determines.

(8) Section 200 *[maximum compensation in the case of further disability]* applies to the calculation of compensation under this section, but the calculation must not be limited by reference to average earnings at the time of injury.

(9) Periodic payments to an applicant worker that are increased or established under this section must not exceed the maximum the Board would establish, at the time of the reconsideration decision, for a worker in an occupational category similar to that of the applicant worker before the

injury if that other worker had a compensable disability similar to the compensable disability of the applicant worker.

(10) A reconsideration decision under this section must not result in periodic payments to a worker being less than they would have been if no application had ever been made under this section.

(11) The effective date for the commencement of an increase or establishment of compensation under this section is the date the application for reconsideration is received by the Board.

(12) A worker may reapply under this section for reconsideration of the worker's compensation 10 years after the worker's most recent application under this section.

Sections 194, 195, and 196:

See Item C6-36.00.

3. Reconsideration of Prescribed Compensation Claims Regulation

Section 1:

In this regulation, "Act" means the *Workers Compensation Act*.

Section 2:

Section 203 *[reconsideration of prescribed compensation claims]* of the Act applies to the following claims:

(a) the worker continues to have a compensable disability sustained more than 10 years before the worker's application under section 203(2) of the Act or section 24 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as applicable, and permanent disability compensation was determined by the Board based on a percentage of total disability of 12% or greater for that compensable disability;

(b) the worker continues to have a compensable disability sustained more than 10 years before the worker's application under section 203(2) of the Act or section 24 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as applicable, and permanent disability compensation was determined by the Board for an injury involving the spinal column;

(c) the worker continues to have a compensable disability sustained more than 10 years before the worker's application under section 203(2) of the Act or section 24 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as applicable, and permanent disability compensation was determined by the Board on or after October 1, 1977 for an injury to a part of the body other than the spinal column;

(d) the worker

(i) continues to have one compensable disability with a percentage of total disability of 5% or greater sustained more than 10 years before the worker's application under section 203(2) of the Act, or section 24 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, and

(ii) also continues to have one or more compensable disabilities sustained at any time before the worker's application under section 203(2) of the Act or section 24 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as applicable, which, when combined with the compensable disability referred to in subparagraph (i), brings the worker's total permanent disability compensation determined by the Board to a percentage of total disability of 12% or greater for the combined compensable disabilities.

Section 3:

For the purposes of section 2(d)(ii), the compensable disabilities may be the result of one or more injuries that were the subject of one or more claims under the Act, the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, or both.

POLICY

A. RECONSIDERATION OF PRESCRIBED COMPENSATION CLAIMS UNDER SECTION 203

Workers may apply for reconsideration of certain compensation claims under section 203 of the *Act*.

Section 203 sets out various criteria, including:

- which claims this section applies to;
- how compensation is calculated;

- the maximum and minimum for periodic payments;
- the commencement date of new periodic payments; and
- when workers may reapply.

Section 203(4) of the *Act* provides:

> Despite section 122(1) *[Board decisions are final]*, if a worker's application under this section is with respect to a claim for compensation to which this section applies,
>
> (a) the Board must reconsider the compensation provided to the worker, and
>
> (b) if, having regard to the projected loss of income resulting from the worker's disability, the Board considers that the worker is not receiving adequate compensation, the Board must increase or establish periodic payments accordingly.

i. Claims to Which Section 203 Applies

Section 203 provides, in part:

> (1) This section applies to the claims for compensation that the Board may, by regulation, determine.
>
> (2) A worker may apply for reconsideration of compensation payable to the worker if
>
> (a) the worker's claim is of a type prescribed under subsection (1),
>
> (b) the worker continues to have a compensable disability that was sustained more than 10 years before the worker's application under this section is made, and
>
> (c) either
>
> (i) the permanent disability compensation determined by the Board for the worker was based on a percentage of total disability of 12% or greater, or
>
> (ii) the worker's case is of a kind in which the Board uses a projected loss of earnings method in calculating the compensation.
>
> ...

The Board's regulation issued under section 203 is set out above.

Section 203(3) provides that even though a worker with a permanent disability has received compensation that has been wholly or partly commuted, or compensation for a fixed term, the worker may apply under section 203; in which case the worker is deemed to be still receiving the periodic payments that have been commuted, or the life equivalent of the periodic payments made for a fixed term.

ii. Calculation of Compensation under Section 203

Section 203 provides, in part:

> (5) For the purposes of subsection (4), the Board must consider compensation to be adequate if,
>
> (a) in the case of a worker who is under 65 years of age, the amount of compensation provided to the worker is at least 75% of the projected loss of earnings resulting from the worker's disability, and
>
> (b) in the case of a worker who is 65 years of age or older, the amount of compensation provided to the worker is at least 75% of the projected loss of retirement income resulting from the worker's disability.
>
> (6) Periodic payments increased or established under this section for a worker who is under 65 years of age are subject to readjustment, by reference to subsection (5)(b), on the worker reaching 65 years of age.
>
> (7) The calculation of compensation under this section must be made in the manner the Board determines.
>
> ...

B. APPLICANTS UNDER 65 YEARS OF AGE

In applying section 203(5)(a), for a worker who is under 65 years of age, the Board must determine the projected loss of earnings resulting from the worker's disability. This involves three steps:

1. A forward projection of the earning capability of the worker as it existed prior to the disability.

2. A projection of the present earning capability of the worker.

3. A determination of the extent to which any difference between (1) and (2) is a result of the disability.

These calculations are made primarily by reference to evidence in the particular case, with two exceptions. A table of monthly average wage rates in British Columbia (see Appendix 4 − Supplement No. 1) is used to establish two of the variables; and an age factor is applied to those cases where the worker became permanently disabled when the worker was under the age of 23. With regard to the former, a projection of the pre-disability earning capacity is made by comparing the worker's actual pre-injury earnings, limited by the maximum in effect at the time of the injury, with the monthly average wage rate in the table for that year and applying the same ratio to the average wage in the table for the year when the calculation is being made. In making this projection, no account is taken of promotions which the worker might have obtained if the worker had not been injured.

C. APPLICANTS 65 YEARS OF AGE OR OLDER

In order to apply section 203(6) when the worker reaches age 65, if the Board adjusts the worker's permanent disability benefits using section 203(5)(a), the adjustment is diarized for review three months prior to the worker attaining 65 years of age. This adjustment is referred to as a "term adjustment", because it is only paid for a period of time: from the time the Board adjusts the compensation under section 203, to the date the worker reaches 65 years of age.

In applying section 203(5)(b), for a worker who is 65 years of age or older, the Board must determine the projected loss of retirement income resulting from the worker's disability. This involves a determination of:

1. The retirement income that the worker would have been likely to be receiving if the worker had not sustained the disability.

2. The retirement income the worker is receiving.

3. A determination of the extent to which any difference between (1) and (2) results from the disability.

Here again, the determinations are made to some extent by reference to evidence in the particular case; but two standard formulae are used with regard to two important items.

The first relates to retirement income from savings. Many workers save part of the earnings accrued during their working lives, and these savings, or income from the savings, become part of retirement income. The Board must consider, therefore, the loss of this element of retirement income resulting from the disability. To determine loss of retirement income from savings, a standard formula is used, based on such evidence as the Board has been able to obtain from aggregated data relating to the savings habits of Canadian families.

The second item to be considered by a standard formula is the loss of retirement income from earnings by people who are 65 years of age or older. The formula selected is to use a flat rate cash amount per month for each percentage of disability.

D. READJUSTMENTS FOR WORKERS WHO WERE 65 YEARS OF AGE AT THE TIME OF APPLICATION

When a worker, whose permanent disability benefits were adjusted using section 24 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492 or section 203(5)(a) of the *Act* reaches 65, the Board readjusts the permanent disability benefits under section 203(6) in the following manner:

1. When the diarized section 203 adjustment comes up for review three months prior to the worker attaining 65 years of age, the file will be considered in accordance with the procedures developed for calculating compensation for workers aged 65 or older set out above. For the purpose of this calculation, the original functional permanent disability benefits as determined under section 23(1) of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492 or section 195 of the *Act*, in effect prior to any previous adjustment under section 24 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, or section 203 of the *Act*, plus applicable cost of living adjustment as described in Item C7-51.00, will be regarded as the permanent disability benefits in effect at age 65.

2. The term adjustment payable to age 65 automatically terminates when the worker reaches age 65. The adjustment calculated as per item (2) above then comes into effect. These new permanent disability benefits will be the higher of the original permanent disability benefit amount plus cost of living adjustments as described in Item C7-51.00 or the adjusted permanent disability benefit determined in reference to the calculation for workers aged 65 or older.

The detailed calculation formulae are set out in Appendix 4 to this manual.

i. Maximum and Minimum Periodic Payments under Section 203

Section 203(8) provides, “Section 200 *[maximum compensation in the case of further disability]* applies to the calculation of compensation under this section [section 203], but the calculation must not be limited by reference to average earnings at the time of injury.”

Section 203(9) provides, “Periodic payments to an applicant worker that are increased or established under this section must not exceed the maximum the Board would establish, at the time of the reconsideration decision, for a worker in an occupational category similar to that of the applicant worker before the injury if that other worker had a compensable disability similar to the compensable disability of the applicant worker.”

Section 203(10) provides that a decision under this section must not result in periodic payments to a worker being less than they would have been if no application had ever been made under this section.

ii. Date When New Periodic Payments Commence under Section 203

Section 203(11) provides that the effective date for the commencement of an increase or establishment of compensation under this section is the date the application for reconsideration is received by the Board.

iii. Reapplication under Section 203

Section 203(12) provides:

> A worker may reapply under this section for reconsideration of the worker's compensation 10 years after the worker's most recent application under this section.

E. COMMUTATIONS OF NEW PERIODIC REINSTATED COMMUTATIONS

If the Board has reinstated periodic payments for permanent disability under section 26 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, or reinstates periodic payments for permanent disability under section 223 of the *Act*, the Board will not generally allow a further commutation. However, the Board does have discretion to permit this in unusual cases.

EFFECTIVE DATE:	January 1, 2021
AUTHORITY:	Section 203 of the *Act*; and Reconsideration of Prescribed Compensation Claims Regulation, B.C. Reg. 177/2013.
CROSS REFERENCES:	Section 223(1) of the *Act*.
HISTORY:	December 1, 2025 – Housekeeping change to update internal cross-references, consequential to reformatting and renumbering Chapter 7, *Protection of and Deductions from Benefits*. February 1, 2022 – Housekeeping amendments. January 1, 2021 – This policy resulted from the consolidation of former policy items #46.00, #46.01, #46.02, #46.03, #46.04, #46.05, and #46.20, consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1, including updating the language, renaming of policy, renumbering from policy item #46.15 to policy item #46.20, and removing language that is out of date. August 1, 2013 – Policy updated to mirror then section 24 regulation change. Title change and housekeeping amendment.
APPLICATION:	Applies to all decisions, including appellate decisions, made on or after January 1, 2021.

RE: Protection of Benefits **ITEM: C7-47.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the protection of a worker's benefits under the *Act.*

2. The Act

Section 118:

(1) An employer must not, either directly or indirectly,

(a) deduct from the wages of a worker of the employer any part of an amount that the employer is or may become liable to pay into the accident fund or otherwise under a compensation provision, or

(b) require or permit a worker of the employer to contribute in any manner toward indemnifying the employer against a liability that the employer has incurred or may incur under a compensation provision.

(2) A person who contravenes subsection (1)

(a) commits an offence, and

(b) is liable to repay to a worker any amount

(i) deducted from the worker's wages in contravention of subsection (1)(a), or

(ii) that the worker has been required or permitted to contribute in contravention of subsection (1)(b).

Section 119:

A worker may not agree with the worker's employer to waive or to forego any benefit to which the worker or the worker's dependants are or may become entitled under the compensation provisions, and every agreement to that end is void.

POLICY

A. INTRODUCTION

The *Act* contains provisions which prevent an employer from inhibiting a worker from claiming compensation and prevent persons from obtaining the funds which the Board owes to the worker. There are however, exceptional cases where benefits may be diverted to someone other than the worker or deductions made in respect of money the worker owes to others (see also Items C7-48.00, C7-48.10, C7-49.00, and C7-49.10).

The *Act* and the Board's policies also contain provisions which ensure that the monetary value of benefits is not unfairly reduced because of inflation or delays in payment by the Board (see Items C7-50.00 and C7-51.00).

B. ACTIONS BY EMPLOYERS

The obligations of an employer to report the occurrence of occupational injuries and diseases to the Board and to refrain from inhibiting a worker from reporting such occurrences to the Board are discussed in policy in Items C12-94.00 and C12-94.20. There are additional provisions which prevent an employer from directly or indirectly attempting to prevent a worker from exercising the worker's right to receive workers' compensation.

i. Agreements to Waive or Forego Benefits

Section 119 of the *Act* is applicable whether a contract provides in express terms that no benefits under the *Act* are payable to a worker of the employer, or whether it seeks to achieve the same objective by more subtle means, such as by describing the parties as independent contractors in circumstances in which the relationship is, in substance, one of employment. If there is any suggestion that section 119 has been violated, the claim should be referred immediately to a Director.

ii. Contributions from Workers to Employer

Section 118(2) of the *Act* provides that a person who contravenes section 118(1) commits an offence and is liable to repay to a worker any amount:

- deducted from the worker's wages in contravention of section 118(1)(a), or
- that the worker has been required or permitted to contribute in contravention of section 118(1)(b).

The maximum fine for the offence referred to in section 118(2) is set out in Appendix 5 to this *Manual*.

EFFECTIVE DATE:	Section B.i is effective June 1, 2009.
AUTHORITY:	Sections 118 and 119 of the *Act*.
CROSS REFERENCES:	Item C12-94.00, *Responsibilities of Employers*; Item C12-94.20, *Employer or Supervisor Must Not Attempt to Prevent Reporting*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #47.00, #47.10, #47.11, and #47.20, consequential to reformatting and renumbering policies in Chapter 7, *Protection of and Deductions from Benefits*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted reference to Compensation Services Department.
APPLICATION:	Section B.i applies on or after June 1, 2009.

RE:	Assignments, Charges or Attachments of Compensation	ITEM:	C7-48.00

BACKGROUND

1. Explanatory Notes

This policy provides guidance on assignments, charges and attachments of compensation under the *Act.*

2. The Act

Section 120:

(1) The following apply to an amount payable as compensation or by way of commutation of a periodic payment in respect of compensation:

(a) the amount is not capable of being assigned, charged or attached;

(b) the amount must not pass by operation of law except to a personal representative.

(2) A claim must not be set off against an amount referred to in subsection (1), except for money

(a) advanced by way of financial or other social welfare assistance owing to the government, or

(b) owing to the accident fund.

Section 232(3):

If an order for spousal support or child support has been made against a worker by a court of competent jurisdiction, the Board may divert all or part of the compensation payable to the worker from the worker for the benefit of the worker's spouse or children.

POLICY

A. SOLICITORS' LIENS

The statutory lien provided for solicitors under section 79 of the *Legal Profession Act* is not applicable to workers' compensation. If the solicitor had any right to a lien at

common law or in equity, that right is abrogated by the terms of section 120 of the *Act*. Compensation funds cannot, therefore, be paid to a solicitor acting for a worker. Nor would the Board induce the same result by making the cheque payable to the worker and sending it in care of the solicitor.

B. MONEY OWING BY WORKER TO OTHER AGENCIES

A worker may receive benefits from other governmental or non-governmental agencies while awaiting the adjudication or a review or appeal of the worker's compensation claim with the Board. If the worker eventually receives compensation benefits for the same period, the agency may have a claim against the worker for reimbursement of the funds advanced by it. A British Columbia government agency can claim reimbursement for money advanced to the worker as financial or other social welfare assistance.

The restrictions on the attachment and assignment of compensation created by section 120 of the *Act* do not generally apply to the Federal Government. As a result, in some instances, the Federal Government could also claim reimbursement for payments made under federal programs.

In the case of health and welfare plans or similar insurance plans, while the *Act* in section 120 does not permit direct refunds to such agencies, the Board may, on receipt of a worker's signed authorization, mail cheques payable to the worker in care of the agency.

In those cases where an inquiry is received from an insurance company or other health and welfare plan, the Board may provide the requested information as long as a signed consent from the worker is on file identifying both the Board and the insurance company. See also Item C12-99.50.

i. Employment Insurance

The essence of the arrangement between the department continued under the *Department of Employment and Social Development Act* (Employment and Social Development Canada – "ESDC") and the Board, as reflected in the respective statutes, is that if a person is eligible for workers' compensation, the Board is in the position of first payer. If a worker receives Employment Insurance benefits and subsequently receives workers' compensation benefits in respect of the same period, under the *Employment Insurance Act* the worker is under an obligation to reimburse ESDC; but that is a matter between the worker and the ESDC. There is no provision under the *Workers Compensation Act* for compensation benefits to be withheld because of the receipt of Employment Insurance benefits.

ii. Social Assistance Payments

Deductions from compensation may be made in respect of social assistance payments made to the worker by British Columbia.

When a person who may be entitled to compensation receives social assistance payments, British Columbia may require the person to execute an assignment to it of any benefits received from the Board. The assignment is then passed on to the Board to notify it to deduct from the worker's compensation benefits the amount owed to British Columbia.

The rules set out below are followed in respect of assignments of compensation made by a worker to British Columbia.

1. No overpayment of compensation is declared and sought to be recovered in respect of payments of compensation made prior to the receipt of an assignment of benefits made by a worker to British Columbia.

2. In respect of payments of compensation made after receipt of the assignment:

   (a) Wage-Loss Benefit Payments

   Refunds will only be made to British Columbia for wage-loss benefit periods which are concurrent with periods where assistance has been paid and only up to the amount of the assistance paid for that period.

   (b) Monthly Permanent Disability Benefit Payments

   British Columbia will be refunded up to the monthly value of the permanent disability payment for concurrent periods. This will usually apply only to retroactive payments. Ongoing assistance, if being paid, will be adjusted by British Columbia beyond the implementation date of the permanent disability benefits.

   (c) Permanent Disability Benefits: Lump Sum Cash Payments or Commutations

   If a lump sum is paid or a commutation is provided, British Columbia will be reimbursed the equivalent amount of the monthly permanent disability benefit that would otherwise have been payable to the worker. This will be for the same period of time covered by the assistance payment. This will only apply up to the amount of assistance paid by British Columbia for that period. For lump sum payments, this will generally only occur where the lump sum is being paid on a retroactive basis.

(d) Rehabilitation Allowances

British Columbia has agreed not to request an Assignment of Benefits from rehabilitation allowances paid under section 155 of the *Act*.

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

The worker is advised when social assistance payments are being deducted from workers' compensation benefits.

iii. Requirements to Pay (Federal)

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

C. WORKER NOT SUPPORTING DEPENDANTS

Section 232(3) of the *Act* provides that if an order for spousal support or child support has been made against the worker by a court of competent jurisdiction, the Board may divert all or part of the compensation payable to the worker from the worker for the benefit of the worker's spouse or children.

If a request is received to divert compensation payments under the authority of section 232(3), it must be supported by a court order.

Where compensation is being diverted under section 232(3), any cost of living adjustments are apportioned between the payment made to the worker and the diverted payment.

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

D. PAYMENT TO SURVIVING SPOUSE FREE FROM DEBTS OF DECEASED

Section 231(4) of the *Act* provides that, "Any compensation owing or accrued to a worker for a period not longer than 3 months before the worker's death may, at the discretion of the Board, be paid to a surviving spouse or a person who takes charge of the funeral arrangements, free from debts of the deceased."

EFFECTIVE DATE:	Sections A and C are effective February 1, 2006. Sections B (except B.ii and B.iii) and B.i are effective June 1, 2009. Section B.ii is effective September 1, 2020. Section B.iii is effective July 13, 2005.
AUTHORITY:	Sections 120, 231, and 232 of the *Act*.
CROSS REFERENCES:	Item C12-99.50, *Disclosure of Information – Other Matters*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #48.00, #48.10, #48.20, #48.21, #48.22, #48.23, #48.30, and #48.50, consequential to reformatting and renumbering policies in Chapter 7, *Protection of and Deductions from Benefits*. September 1, 2020 − Policy amended to address an inconsistency with practice. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. March 1, 2012 – Housekeeping changes made in accordance with amendments to the *Act*. November 24, 2011 – Housekeeping amendments made in accordance with amendments to the *Act*. June 1, 2009 – Updated references to then Human Resources and Skills Development Canada and the *Employment Insurance Act*. Deleted reference to Board officer. February 1, 2006 – Minor editorial amendments were made. July 13, 2005 – Amendments clarified that restrictions on the attachment and assignment of compensation created by then section 15 of the *Act* do not generally apply to the Federal Government. As a result, in some instances, the Federal Government could also claim reimbursement for payments made under federal programs. Deleted statement indicating that there is no provision under the *Act* for the worker's obligation to repay employment insurance benefits to be enforced by the Board.
APPLICATION:	Minor editorial amendments made on February 1, 2006 do not affect the application of Sections A and C. Sections B (except B.ii and B.iii) and B.i apply on or after June 1, 2009. Section B.ii applies to all decisions made on or after September 1, 2020. Section B.iii applies to all benefits, including retroactive awards of benefits, payable under the *Act* on or after July 13, 2005.

RE: Overpayments/Money Owed to the Board **ITEM: C7-48.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on overpayments of compensation and other money owed to the Board.

2. The Act

Section 120(2), in part:

> A claim must not be set off against an amount referred to in subsection (1), except for money
>
> …
>
> (b) owing to the accident fund.

POLICY

A. INTRODUCTION

Section 120 of the *Act* provides an exception to its general prohibition of assignments, charges or attachments of compensation payments in respect of money "owing to the accident fund". The Board may therefore deduct from compensation benefits the amount of money owed to it by the person entitled to receive them.

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

Assessments owing by a limited company may be deducted from compensation payments made to the sole principal of that company or, where there is more than one principal, from payments made to a principal who is personally responsible for the non-payment of assessments (see Item AP3-120-1 of the *Assessment Manual*). This also applies to situations involving Personal Coverage premiums owing.

B. WHEN DOES AN OVERPAYMENT OF COMPENSATION OCCUR?

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

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

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

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

C. RECOVERY PROCEDURES FOR OVERPAYMENTS

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

1. The Vocational Rehabilitation Services and Compensation Services Departments will conduct the initial collection procedure which will include the Board officer making personal contact with the worker in addition to sending two letters, one immediately and one 30 days later. For overpayments in excess of $500, the second letter advises that unpaid accounts will be turned over to the Board's Collections Section.

2. When the overpayment is 70 days overdue it will be sent to the Board's Collections Section. Unless there is evidence of fraud or misrepresentation, claims for overpayments under $500 are not sent to Collections.

3. A letter will be sent to the worker by a Collections Officer at the 70-day overdue date indicating that the overpayment has been transferred to the Board's Collections Section and suggesting that payment be made within a month in order to avoid possible legal action. This letter will make it clear that the Board is serious about collecting the overpayment.

4. If payment is not received within 30 days, or a reasonable payment plan arranged, the Collections Officer will attempt to make telephone contact with the worker or pay a personal visit.

5. If this does not result in positive arrangements for payment, a final, more strongly worded letter will be sent. An asset search will be conducted and if there is a reasonable expectation that money is collectible, the account will be turned over to the Board's Legal Services Division for attention and action. The result of this action could be the seizing of assets or garnishing wages.

Item C7-50.00 sets out the procedures regarding the crediting of interest to retroactive compensation. In the case of claims overpayments, interest charges only apply to amounts due where the overpayment is the result of fraud, misrepresentation or the withholding of information by the worker. Interest is not charged on overpayments that result from the correction of an error. The charging of interest on an overpayment must be approved by a Manager or a Director.

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

D. RECOVERY OF OVERPAYMENTS ON REOPENINGS OR NEW CLAIMS

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

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

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

i. Bankruptcy

The general law of bankruptcy releases a bankrupt from all claims provable in bankruptcy upon discharge from bankruptcy. Therefore, if an overpayment has been incurred prior to the bankruptcy date, the Board does not take legal proceedings against the discharged bankrupt to recover the overpayment.

Should a subsequent claim be submitted or the claim reopened, no attempt to recover such an overpayment is made.

E. DEDUCTION OF OVERPAYMENTS FROM PERMANENT DISABILITY BENEFITS

If a worker is entitled to permanent partial disability benefits, attempts are made to recover the overpayment prior to paying the permanent disability benefits. Whenever possible, the full amount will be recovered directly from the worker. If recovery is not made prior to the commencement of the permanent disability benefit payments, the recovery may be made from the permanent disability benefit itself either from the initial payment or on the basis of an adjustment to the ongoing permanent disability payments as follows:

(a) non-payment of the full periodic payment amount for a fixed term;

(b) a partial reduction of the permanent disability periodic amount for a fixed term;

(c) a partial reduction of the permanent disability amount for the duration of a worker's entitlement to permanent disability benefits.

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

If a previous permanent disability is being compensated and the overpayment is on a subsequent claim, the Board does not usually elect to recover the overpayment from the prior periodic payment amount. This is an option that is only used as a last resort. The

choice is first given to the worker as to how the worker wishes to repay the overpayment on the understanding that the Board would prefer not to interfere with the ongoing permanent disability benefits.

If payment has been suspended for the purpose of paying off an amount owing to the Board, the worker will, every six months, be sent a statement showing the results of any changes in the permanent disability payment amount because of cost of living adjustments, the amounts credited to the worker's account as a result of the suspension, and the amount still owing.

Periodic payments for permanent disability benefits and dependant benefits are made at the end of each calendar month. Should a worker or dependant die during the month for which a full month's payment has been made, no deduction is made nor is any overpayment declared.

F. DEDUCTION OF OVERPAYMENTS FROM VOCATIONAL REHABILITATION PAYMENTS

An overpayment may be recovered from a vocational rehabilitation assistance payment. Every attempt is, however, made by the Board to have the worker make arrangements to repay the overpayment in some other method rather than reduce a vocational rehabilitation payment. Recovery from a vocational rehabilitation payment would only occur under exceptional circumstances.

G. REVIEWS AND APPEALS ON OVERPAYMENTS

A request for a review by the Review Division may be made on the question of whether the worker owes money to the Board and, if so, the amount owing.

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

H. WAIVER OF OVERPAYMENT RECOVERIES

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

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

> The President or a Vice-President (or Directors for overpayments under $1,000) will have discretionary authority to waive recovery procedures for overpayments where:
>
> 1. in their judgment, severe financial hardship would result (it is not considered that amounts under $1,000 should be deemed as meeting this requirement); or
>
> 2. it is considered unreasonable or inadvisable to proceed with recovery.

In no case will recovery be waived if there was fraud or misrepresentation. Approval to waive recovery, when granted, does not constitute forgiveness of the debt. In some instances, at the discretion of a Vice-President (or Director for waivers under $1,000), a recovery waiver may be granted even though permanent disability benefits are being paid or will be paid. Should a further claim be recorded or a later reopening accepted where a prior waiver has been approved, the question of initiating recoveries must first be discussed with a Vice-President or Director who approved the waiver.

I. UNPAID ASSESSMENTS

Unpaid and overdue assessments are treated in the same manner as overpayments if a claim is later received from an employer or principal of the limited company responsible for the debt or an independent operator who has purchased but not fully paid for Personal Coverage. If, at the time of the claim, the worker is working for another company or organization, the decision whether or not to recover the overdue assessment from compensation entitlements will be made by the Board officer in the Finance Division who has been assigned that authority by the President, or a Director or a delegate. Recoveries will not be made from surviving spouses or dependants where the claim is the result of a fatality and the worker was employed with an employer other than the employer owing the assessments.

EFFECTIVE DATE:	Section B is effective October 1, 2007. Section C is effective December 1, 2022. Sections F, G, H, and I are effective June 1, 2009.
AUTHORITY:	Section 120 of the *Act*.
CROSS REFERENCES:	Item AP3-120-1, *Attachment of Compensation*, of the *Assessment Manual*.
HISTORY:	March 2, 2026 – Housekeeping change to update the term “Personal Optional Protection” to “Personal Coverage.” December 1, 2025 – This policy resulted from the consolidation of former policy items #48.40, #48.41, #48.42, #48.43, #48.44, #48.45, #48.46, #48.47, and #48.48, consequential to reformatting and renumbering policies in Chapter 7, *Protection of and Deductions from Benefits*.

April 3, 2023 – Housekeeping changes consequential to implementing the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41).
December 1, 2022 – Policy amended to remove references to re-collection procedures and correct reference to then policy item #48.46.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
November 24, 2011 – Housekeeping amendments were made in accordance with amendments to the *Act.*
June 1, 2009 – Deleted references to Board officers, Compensation Services Division, and Compensation Services.
October 1, 2007 – Revised to remove reference to computer errors.
March 18, 2003 – Deleted the title Manager, Collections, and the substitution of the Board officer in the Finance Division who has been assigned that authority by the President.
March 3, 2003 – Policy amended regarding references to review, the Review Division and the Workers' Compensation Appeal Tribunal, as well as deleted cross-references to payments to children on fatal claims, interim adjudications and appeals.

APPLICATION:

Section B applies on or after October 1, 2007.
Section C applies to all decisions made on or after December 1, 2022.
Sections F, G, H, and I apply on or after June 1, 2009.

RE: Incapacity of a Worker **ITEM: C7-49.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on compensation payments to a worker who is incapacitated.

2. The Act

Section 121:

For the purposes of the compensation provisions,

(a) a worker who is a minor has the capacity of a person who has reached 19 years of age, and

(b) no other person has a cause of action or right to compensation for the personal injury or disablement of the worker except as expressly provided in the compensation provisions.

Section 231, in part:

(1) In the case of payments of compensation to

(a) a minor, or

(b) a person of unsound mind who the Board considers incapable of managing the person's own affairs,

the payments may be made to the person that the Board considers best qualified in all the circumstances to administer the payments, whether or not that person is the legal guardian of the person in respect of whom the payment is being made.

(2) If an injured worker is receiving custodial care in a hospital or elsewhere, periodic payments of compensation due to the worker may be dealt with as follows, regardless of the date of the injury:

(a) in a case of temporary disability of the worker, the payments may be

(i) applied to the maintenance of a home to which the worker is likely to return on the worker's recovery, or

(ii) accumulated by the Board for payment to the worker on the worker's recovery;

(b) in a case of permanent disability of the worker, the payments may be applied toward the cost of the worker's maintenance;

(c) in any case, the payments may be paid to or for the benefit of

(i) the worker, to the extent the worker is able to make use of the compensation for personal needs or is able to manage the worker's own affairs, or

(ii) any person who is dependent on the worker for support.

(3) As a restriction on subsection (2)(b), if the worker is conscious, the Board must pay to the worker, or for the use of the worker, a comfort allowance of at least $306.25 out of each periodic payment.

…

POLICY

A. COMPENSATION BENEFITS WHERE A PUBLIC TRUSTEE HAS BEEN APPOINTED

Compensation benefits due to a worker, where a public trustee has been appointed, will be issued in the name of the worker but sent to the public trustee.

B. WORKER RECEIVING CUSTODIAL CARE IN HOSPITAL

Section 231(2) of the *Act* provides that if an injured worker is receiving custodial care in a hospital or elsewhere, periodic payments of compensation due to the worker may be dealt with as follows, regardless of the date of the injury:

(a) in a case of temporary disability of the worker, the payments may be

(i) applied to the maintenance of a home to which the worker is likely to return on the worker's recovery, or

(ii) accumulated by the Board for payment to the worker on the worker's recovery;

(b) in a case of permanent disability of the worker, the payments may be applied toward the cost of the worker's maintenance;

(c) in any case, the payments may be paid to or for the benefit of

(i) the worker, to the extent the worker is able to make use of the compensation for personal needs or is able to manage the worker's own affairs, or

(ii) any person who is dependent on the worker for support.

Section 231(3) provides that in the case of permanent disability where the Board applies the payments toward the costs of the worker's maintenance, if the worker is conscious, the Board must pay to the worker, or for the use of the worker, a comfort allowance of at least the amount set out below out of each periodic payment.

January 1, 2025	—	December 31, 2025	$299.77
January 1, 2026	—	December 31, 2026	$306.25

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

i. Meaning of Custodial Care in Hospital or Elsewhere in Section 231(2)

Section 231(2) applies if an injured worker is receiving "custodial care in a hospital or elsewhere".

"Custodial care" requires that the worker be undergoing a voluntary or involuntary stay in, and be receiving care from, a hospital or other similar institution. Only long-term or permanent residence in a hospital or similar institution could amount to "custodial care". It does not cover periodic stays in hospital which a worker might have to undergo for the purpose of surgery or other treatment.

A worker is not considered to be receiving "custodial care" when confined to prison or other corrective institution. While the worker might be said to be in involuntary custody, it is not felt that the worker is undergoing "care" for the purpose of the section. The case would be different if the prison or corrective institution were also a hospital. The Board has authority under section 232(1) to discontinue the compensation of workers confined to prison. (See Item C7-49.10.)

ii. Nature of the Board's Authority under Section 231(2)

Section 231(2) clearly confers a discretionary power on the Board with one limitation in the case of a conscious worker with a permanent disability, as addressed by section 231(3).

In exercising the discretion, the Board is free to choose any of the applicable alternatives listed, without regard to the order in which they are set out. There is no obligation on the Board to give any priority to any of the alternative choices set out in the section.

In exercising its discretion under section 231(2), the Board has set its own priorities for the application of the various alternatives in relation to the sub-paragraphs of section 231(2) in Section B.iii of this Item, below.

iii. Application of Section 231(2) in Cases of Temporary Disability

In the case of a worker entitled to temporary disability payments who is receiving custodial care in a hospital or elsewhere, the Board may take any of the alternative courses of action set out in sections 231(2)(a) and 231(2)(c). The Board's priorities for applying these alternatives are set out below in paragraphs 1 to 4.

1. Worker able to use compensation for personal needs or to manage personal affairs

   Under section 231(2)(c)(i), the Board may pay the wage-loss benefit payments to the "worker, to the extent the worker is able to make use of the compensation for personal needs or is able to manage the worker's own affairs." Priority should normally be given to this alternative. To the extent able, the worker should make a personal choice as to how much of the compensation payment to spend on personal needs, how much to contribute to the home and family, and how much to save.

   This provision requires that a judgment be made on an individual basis as to the amount of money which the worker is able to use or manage for personal needs. This may be none, all, or part only of the worker's compensation payment, since payment is to be made to the worker only to the "extent" that the worker is capable of using or managing it.

   A distinction is drawn between the amount the worker can use for personal needs and the amount that the worker can manage. A worker may be capable of managing an amount greater than what can be used for personal needs. On the other hand, there may be the capacity to handle small amounts of money to purchase personal comforts without the worker having any capacity to further manage personal affairs. Where there is an entitlement to wage-loss benefits, these are to be paid in an amount the worker is capable of using for personal needs or in an amount the worker is capable of managing, whichever is greater. Any balance remaining after payment is made to the worker will be applied under alternatives 2 to 4 below.

2. Person dependent on the worker for support

Under section 231(2)(c)(ii), the Board may pay the wage-loss benefit payments to "any person who is dependent on the worker for support". Any balance remaining after payment has been made to the worker under alternative 1 will normally be paid to any dependants living with, and being maintained by, the worker.

Where a person who is dependent on the worker for support lives separate from the worker, payments will be made to the dependant only to the extent that that person was maintained by the worker. Therefore, if the worker was making a regular payment to the dependant, whether voluntarily or by virtue of a separation agreement or court order, the amount of that payment will be paid to the dependant by the Board. Where the worker was making no regular payments or not complying with a separation agreement or court order, judgment must be made as to the amount that would have been paid to the dependant had the worker been capable of managing personal affairs.

If compensation is payable to the worker's children under this provision, it may be paid to a foster parent or home or other person or institution looking after them.

Where compensation is paid under alternative 1 on the basis that the worker is capable of managing the worker's own affairs but the worker does not support the worker's spouse and the worker's children, the Board may be able to divert all or part of the worker's compensation to the worker's spouse or children under section 232(3). (See Item C7-48.00.)

3. Maintenance of a home

The Board may apply the worker's temporary disability wage-loss benefit payments to the "maintenance of a home to which the worker is likely to return on the worker's recovery". Where payments are made to the worker under alternative 1 above on the basis that the worker can manage personal affairs, or are made to the dependants living with the worker under alternative 2, it is expected that the worker or dependants will use the money to maintain their home. Alternative 3 should only be of relevance when the worker is incapable of managing the property alone and there are no dependants living under the same roof.

Payments for the maintenance of the worker's home should normally be made to the person who is managing the property on the worker's behalf. The Board should not normally undertake the management of a worker's property.

4. Accumulation of balance

Wage-loss benefit payments may be "accumulated by the Board for payment to the worker on the worker's recovery". Any balance remaining after payments have been made under alternatives 1 to 3 set out above should be accumulated until the worker has recovered the capacity to manage personal affairs. The accumulations should then be paid to the worker either as a lump sum or, if this is in the worker's best interests, by instalments over a period of time.

iv. Application of Sections 231(2) and 231(3) in Cases of Permanent Disability

In the case of a worker entitled to permanent disability benefit payments who is receiving custodial care in a hospital or elsewhere, the Board may take any of the alternative courses of action set out in sections 231(2)(b), 231(2)(c)(i), and 231(2)(c)(ii). The Board's priorities for dealing with these cases are set out below.

1. Worker able to use money for personal needs

Under section 231(2)(c)(i), permanent disability payments will in the first place be paid to the worker to the extent that the worker is capable of using them for personal needs. If a worker is capable of handling greater sums than required for personal needs, section 231(2)(c)(i) authorizes the Board to pay these greater amounts to the worker and this is the practice of the Board in the case of temporary disability. However, in the case of permanent disability, the exercise of this authority would conflict with the object of the section to prevent the accumulation of estates. It is not, therefore the Board's practice to pay more to the permanently disabled worker than required for personal needs.

2. Person dependent upon the worker for support

Any balance remaining after the application of alternative 1 above will be applied for the benefit of any dependants of the worker according to the same principles as for temporary disability.

3. Maintenance costs

Any balance remaining after the application of alternatives 1 and 2 above will be applied toward the cost of the worker's maintenance. This applies to the full cost of custodial care, not just the value of the worker's room and board. It only applies when the Board is paying the cost of maintenance as part of the costs of a compensation claim.

If a worker is conscious and compensation is being applied toward the cost of maintenance, the worker must receive a comfort allowance of a minimum amount which is subject to cost of living adjustments as described in Item C7-51.00. The amount of this minimum is set out in Section B of this Item. Comfort allowance is interpreted to

mean the monies payable to the worker under alternative 1 above which the worker is able to use for personal needs. The result is that if the worker is conscious, the minimum amount payable for personal needs is the amount set out in Section B of this Item.

Any balance remaining after payment of the cost of maintenance will be paid to the worker to the extent the worker is able to manage personal affairs. To the extent the worker is not able, it will be paid to the person who is best qualified to administer it under the terms of section 231(1).

v. Application of Section 231 on a Change of Circumstances

A situation may arise where the compensation of a worker receiving custodial care is being applied to the cost of maintenance, but the worker becomes able to leave the hospital and live at home. Section 231(2)(b) would then cease to have any application so that it would be necessary to resume periodic payment of the worker's permanent disability benefits. However, the worker would not be entitled to receive the payments previously applied to the cost of maintenance. If, following departure from custodial care, the worker remains incapable of handling personal affairs, consideration should be given to the application of section 231(1).

It may also happen that what was initially thought to be a temporary disability might turn out to be permanent. As soon as this is definitely known, consideration should be given to using any part of the periodic payments not required for the worker's personal needs or dependants' needs, for the cost of maintenance. This would only apply to future compensation payments.

C. PAYMENT OF PUBLIC GUARDIAN AND TRUSTEE, AND COMMITTEE FEES

The Board pays the fees charged to a worker by the Public Guardian and Trustee or Committee for managing the worker's entire estate when the following conditions are met:

1. The worker is incapable of managing the worker's own affairs and the Public Guardian and Trustee or Committee administers the worker's estate;

2. The worker's incapacity to manage the worker's own affairs results from a compensable injury or disease; and

3. The Public Guardian and Trustee or Committee is appointed to manage the worker's affairs under the *Public Guardian and Trustee Act*, or the *Patients Property Act*, or equivalent statute.

The Board will pay the Public Guardian and Trustee and Committee fees in accordance with the fee schedule established by the Public Guardian and Trustee. Fees may

include the account review fee paid to the Public Guardian and Trustee by Committees and the accountant's fees for preparing the account summaries.

The Board will pay the Committee fees after the Public Guardian and Trustee has approved the accounts.

AUTHORITY: Sections 121, 231, and 232 of the *Act*.

CROSS REFERENCES: Item C7-48.00, *Assignments, Charges or Attachments of Compensation*;
Item C7-49.10, *Imprisonment of a Worker*;
Item C7-51.00, *Cost of Living Adjustments to Periodic Payments*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY: December 1, 2025 – This policy resulted from the consolidation of former policy items #49.00, #49.10, #49.11, #49.12, #49.13, #49.14, #49.15, and #49.30, consequential to reformatting and renumbering policies in Chapter 7, *Protection of and Deductions from Benefits*.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
June 30, 2002 – Housekeeping changes consequential to implementing the *Workers Compensation Amendment Act, 2002*.
The principles for this policy were derived from *Workers Compensation Reporter* Series Decision No. 247 (1977), 3 W.C.R. 127.

RE: Imprisonment of a Worker **ITEM: C7-49.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on compensation to a worker who is confined to prison.

2. The Act

Section 232:

(1) If a worker is confined to prison, the Board may cancel, withhold or suspend the payment of compensation for the period the Board considers advisable.

(2) If compensation is withheld or suspended under subsection (1), the Board may pay the compensation or any portion of it to

(a) the worker's spouse or the worker's children, or

(b) a trustee appointed by the Board, who must use the payment for the benefit of the worker, the worker's spouse or the worker's children.

(3) If an order for spousal support or child support has been made against a worker by a court of competent jurisdiction, the Board may divert all or part of the compensation payable to the worker from the worker for the benefit of the worker's spouse or children.

POLICY

This policy deals with the application of sections 232(1) and 232(2) of the *Act*. In considering the payment of compensation under this policy, regard must be given to the individual circumstances of the case.

Sections 232(1) and (2) apply where it is determined that a worker who is receiving benefits is subsequently incarcerated in any place used to confine persons in the course of the administration of the criminal justice system. The section does not apply to situations where a worker is injured while incarcerated.

In applying sections 232(1) and (2), the following definitions apply:

> Cancel: to terminate compensation payments for the period considered advisable – the payments otherwise payable during the period of cancellation are permanently lost to the worker – the payments cannot be redirected.
>
> Suspend: to temporarily terminate compensation payments – the payments are not accumulated by the Board for the worker but may be redirected during the temporary stop in accordance with section 232(2).
>
> Withhold: to temporarily hold back compensation payments – the payments may be accumulated by the Board and paid to the worker upon release from prison, or may be redirected during the temporary hold back in accordance with section 232(2).

The general rule is that vocational rehabilitation benefits will be cancelled during the period of incarceration while the worker is unable to participate in the vocational rehabilitation program. One exception, however, applies to a worker who is entitled to permanent total disability benefits under section 194(1) who requires vocational rehabilitation services and supports due to the nature of the disability.

Health care benefits will generally continue to be paid during incarceration.

Wage-loss benefits (sections 191 and 192) will be suspended during the period of incarceration as there is considered to be no loss of earnings during incarceration. These benefits may be paid, in whole or in part, to the worker's spouse or the worker's children, or to a trustee appointed by the Board to use the payment for the benefit of the worker, the worker's spouse or the worker's children. If not redirected, these benefits are permanently lost during the period of incarceration.

Permanent disability benefit periodic payments based on the loss of function method of assessment (sections 194 and 195) will either continue to be paid or be withheld during the period of incarceration. If withheld, these benefits may be paid, in whole or in part, to the worker's spouse or the worker's children, or to a trustee appointed by the Board to use the payments for the benefit of the worker, the worker's spouse or the worker's children. Benefits neither paid to the worker nor redirected will be paid to the worker on release.

Permanent disability benefit periodic payments based on the projected loss of earnings method of assessment (section 196) will be suspended during the period of incarceration. These benefits may be paid, in whole or in part, to the worker's spouse or the worker's children, or to a trustee appointed by the Board to use the payment for the benefit of the worker, the worker's spouse or the worker's children. If not redirected, these benefits are permanently lost during the period of incarceration; however, the worker will be entitled, during the period of confinement, to the section 195 benefits the worker would have been granted had there been no section 196 consideration.

Confinement under section 232(1) only includes those circumstances where the worker is prevented from seeking or obtaining employment for regular wages under an employee/employer relationship. Thus, ongoing entitlement to benefits will be determined once the worker is released on day parole and is no longer considered to be "confined" to jail or prison.

When an incarcerated worker whose benefits have been cancelled, suspended or withheld becomes eligible to participate in a work release program, but is unable to do so because of the effects of a work-caused disability accepted under the claim, benefits may be reinstated from that point.

The power to redirect payments to dependants is exercised if the worker was supporting the worker's spouse or the worker's children prior to the imprisonment. The proportion of the compensation paid to the worker's spouse, the worker's children, or a trustee, depends on the number of dependants and their needs. If the worker was not supporting them, the power is not exercised unless there is a court order against the worker, in which case the amount provided for in the order will be paid. The power to pay the compensation to a trustee for the benefit of the worker depends on the reasonable needs of the worker while incarcerated.

AUTHORITY: Section 232 of the *Act*.

HISTORY: December 1, 2025 – This policy resulted from former policy item #49.20, consequential to reformatting and renumbering policies in Chapter 7, *Protection of and Deductions from Benefits*.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

RE: Interest **ITEM: C7-50.00**

BACKGROUND

1. Explanatory Notes

This policy sets out when a worker is entitled to interest on compensation benefits and the method for calculating.

2. The Act

Section 1, in part:

> "**compensation**" includes health care;
>
> …

Section 231.1:

(1) In this section, **"effective date"**, in relation to a payment of compensation, means the date on which entitlement to the payment of compensation arises, as determined by a review officer or the appeal tribunal.

(2) Interest must be paid on any amount of compensation that

(a) is determined to be payable following a review under Part 6 *[Review of Board Decisions]* or an appeal under section 288 *[review decisions that may be appealed]*, and

(b) remains unpaid for a period of at least 180 days after the effective date.

(3) Interest payable under subsection (2) must be calculated in accordance with the policies of the board of directors and begins on the effective date.

(4) Despite this section, if interest is payable on an amount of compensation under section 312 *[payment of compensation following appeal]*, interest is not payable under this section on that amount of compensation in respect of the same period.

Section 312:

(1) If the appeal tribunal's decision on an appeal requires the payment of compensation, all or part of which was deferred under section 275(3) *[payment following review decision]*, interest must be paid on the deferred amount of that compensation as specified in subsection (2).

(2) Interest payable under subsection (1) must be calculated in accordance with the policies of the board of directors and begins

(a) 41 days after the review officer made the appealed decision, or

(b) on an earlier day determined in accordance with the policies of the board of directors.

POLICY

A. PROVISION OF INTEREST

With respect to compensation matters, the *Act* provides express entitlement to interest only in the situations covered by sections 231.1 and 312.

i. Section 231.1

Section 231.1 requires interest be paid when the Review Division or Workers' Compensation Appeal Tribunal determines a worker is entitled to compensation and an amount of the compensation remains unpaid for 180 days or more after the effective date, as described below.

a. Compensation determined to be payable

For interest to be payable under section 231.1, there must be a determination of entitlement to compensation made by the Review Division or the Workers' Compensation Appeal Tribunal. This includes a Review Division or Workers' Compensation Appeal Tribunal determination on entitlement generally, such that interest may be payable under section 231.1 on an amount of compensation the Board determines is reasonably payable following the review or appeal determination.

Compensation means all payments under Part 4 of the *Act*.

The Review Division may refer a decision back to the Board, with or without directions, so the Board can conduct further investigations and make a new decision. If the Board's new decision determines the worker is entitled to compensation payable for the

period of time prior to the date of the new decision, interest is not payable as the Review Division did not determine compensation entitlement.

b. Unpaid for at least 180 days

Interest under section 231.1 also requires an amount of the compensation be unpaid for 180 days or more.

Interest is only payable on an amount of compensation that remains unpaid for at least 180 days after the payment effective date. The effective date for the purpose of section 231.1 is the date the worker's entitlement to the payment of compensation arises, which means the date the right to each payment arises. Therefore for compensation payable by periodic payments, each payment has its own effective date. No interest is payable on any amount paid within 180 days of the payment effective date. This means in some cases, interest will be payable on only a portion of the total compensation owing.

c. Interest start date

Where interest is payable on a payment of compensation under section 231.1, interest will be paid beginning on the effective date.

ii. Section 312

See Item C12-100.30.

B. METHOD TO CALCULATE INTEREST

In all cases where a decision to pay interest is made, the Board will pay simple interest at a rate equal to the prime lending rate of the banker to the government (i.e. the CIBC). During the first 6 months of a year interest must be calculated at the interest rate as at January 1. During the last 6 months of a year interest must be calculated at the interest rate as at July 1.

For practical reasons, certain mathematical approximations may be used in the calculations.

The rate of interest provided in this policy will also be used in the calculation of overpayments as outlined in Item C7-48.10.

EFFECTIVE DATE:	April 3, 2023
AUTHORITY:	Sections 1, 231.1, and 312 of the *Act*.
CROSS REFERENCES:	Item C7-48.10, *Overpayments/Money Owed to the Board*; Item C12-100.30, *Payment of Claims Pending Appeals*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from former policy item #50.00, consequential to reformatting and renumbering policies in Chapter 7, *Protection of and Deductions from Benefits*. April 3, 2023 – Amendments made to provide for the payment of interest pursuant to new section 231.1 of the *Workers Compensation Act.* December 1, 2022 – Housekeeping amendment. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. November 25, 2015 – Application statement revised by Board of Directors Decision No. 2015/11/25-01. January 1, 2014 – Policy changed to reflect the removal of the blatant Board error test; effective January 1, 2014. June 1, 2009 – Deleted references to Board officers. March 1, 2006 – Amendments made to provide for the payment of interest to the dependants of deceased workers in respect of retroactivity of then section 17 payments that are the result of a blatant Board error; applied to all decisions, including appellate decisions, made on or after March 1, 2006.
APPLICATION:	Applies to all decisions, including appellate decisions, made on or after April 3, 2023.

RE: Cost of Living Adjustments to Periodic Payments ITEM: C7-51.00

BACKGROUND

1. Explanatory Notes

This policy sets out the method for indexing periodic payments of compensation to a worker, as well as the method for adjusting dollar amounts in the *Act*.

2. The Act

Section 333, in part:

(1) Subject to subsection (2), the Board must adjust every dollar amount referred to in this Act on January 1 of each year by applying the percentage change in the consumer price index for Canada, for all items, for the 12-month period ending on October 31 of the previous year.

(2) Subsection (1) does not apply to a dollar amount referred to in the following:

(a) section 209(2) *[maximum wage rate for applicable year]*;

(b) section 227 *[compensation for workers injured before 1986]*.

(3) On the Board making an adjustment of a dollar amount under subsection (1), the dollar amount referred to in this Act is deemed to be amended.

…

Section 334:

(1) On or before January 1 of each year, the Board must

(a) determine the percentage change in the consumer price index for Canada, for all items, for the 12-month period ending on October 31 of the previous year, and

(b) if the percentage change under paragraph (a) is greater than 4%, determine a percentage in accordance with subsection (2).

(2) The percentage determined by the Board under subsection (1)(b) must be at least 4% and must not be greater than the percentage change determined under subsection (1)(a).

(3) On January 1 of each year, the Board must adjust, in accordance with subsection (4), the periodic payments of compensation to be paid in the calendar year in respect of an injury or death occurring more than 12 months before the date of the adjustment.

(4) For the purposes of subsection (3), the periodic payments of compensation must be adjusted as follows:

(a) if the percentage change determined under subsection (1)(a) is negative, the adjustment is 0%;

(b) if the percentage change determined under subsection (1)(a) is greater than 4%, the adjustment is equal to the percentage determined under subsection (1)(b);

(c) in any other case, the adjustment is the percentage change determined under subsection (1)(a).

(5) If the Board starts or restarts periodic payments of compensation for an injury or a death that occurred more than 12 months before the payments are started or restarted, the Board must, under this section, adjust all periodic payments as if the payments were made continuously from the date of injury or death.

POLICY

A. GENERAL

Sections 334(1), (2), and (4) of the *Act* provide the method for indexing periodic payments of compensation to a worker.

The Board determines the indexing factor to be applied to periodic payments of compensation to a worker or a dependant in the following manner:

- The Board compares the consumer price index for October of the previous year with the consumer price index for October of the year prior to the previous year.
- If the percentage change between these two consumer price indexes is less than 0%, no adjustment to periodic payments of compensation is made.

- If the percentage change between these two consumer price indexes is greater than 0% but less than or equal to 4%, the indexing factor is the percentage change.

- If the percentage change between these two consumer price indexes is greater than 4%, the indexing factor must be at least 4% but must not be greater than the percentage change.

The resulting indexing factors determined annually are set out below:

Date	Percentage
January 1, 2026	2.163164

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

The resulting indexing factor is applied on January 1 of each year to periodic payments of compensation to be paid in the calendar year in respect of an injury or a death occurring more than 12 months before the date of the adjustment.

If the Board starts or restarts periodic payments of compensation on a date more than 12 months after the date of the worker's injury or death, section 334(5) requires the Board to adjust all periodic payments as if payments were made continuously from the date of injury or death. This means that if payments on a claim are started or restarted more than 12 months after the injury or death, the worker or dependant receives the benefit of any cost of living adjustments occurring in the interim period as if payment had been continuous since the date of injury or death.

Compensation paid to a worker on or after June 30, 2002 will be indexed according to section 334 of the *Act*, irrespective of the date the worker was injured. However, if the Board is paying a retroactive adjustment of compensation to a worker who was injured before June 30, 2002, the indexing rules in section 25 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as it read immediately before June 30, 2002, apply to the compensation benefits that should have been paid to the worker before June 30, 2002. Compensation due to the worker on or after June 30, 2002 will be indexed according to section 334.

Effective December 31, 2003, compensation paid to a dependant of a deceased worker is indexed under section 334 regardless of the date that the worker died. However, if the Board retroactively adjusts compensation in respect of a death that occurred before December 31, 2003, the indexing rules in section 25.1 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as it read immediately before December 31, 2003, apply to the compensation that should have been paid to the dependant before that date. Compensation owing to the dependant on or after December 31, 2003 is indexed under section 334.

Authority to approve adjustments under section 334 has been assigned to the President.

B. DOLLAR AMOUNTS IN THE *ACT*

The Board determines the percentage change to be applied each January 1 to dollar amounts in the *Act* by comparing the consumer price index for October of the previous year with the consumer price index for October of the year prior to the previous year.

The resulting percentage changes determined annually are set out below:

Date	Percentage
January 1, 2026	2.163164

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

When the Board makes the adjustments, those dollar amounts referred to in the *Act* are deemed to be amended.

Sections 333(1) and (3) of the *Act* do not apply to the figures referred to in the maximum wage rate, and other figures referred to in Item C9-69.00.

Authority to approve adjustments under section 333 has been assigned to the President.

Authority has also been assigned to the President to adjust the following amounts, using the formula set out in policy of the applicable Item of the *Manual*:

Amount of Disfigurement Compensation	C6-43.00
Clothing Allowances	C10-82.00
Transportation	C10-83.00
Subsistence Allowances	C10-83.10
Additional Benefits for Severely Disabled Workers	C10-84.00
Transfer of Costs	C17-114.20
Funeral and Other Death Expenses	C8-54.00

The Board adjusts dollar amounts referred to in Part 4, Division 5 − Compensation in Relation to Death of Worker, and section 225 in accordance with section 333. In addition, effective December 31, 2003, the Board adjusts the dollar amounts referred to

in Part 4, Division 5 − Compensation in Relation to Death of Worker, and section 225 and Schedule C of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as it read immediately before June 30, 2002, in accordance with section 333.

EFFECTIVE DATE: Sections A and B are effective December 31, 2003.

AUTHORITY: Sections 333 and 334 of the *Act*.

HISTORY: December 1, 2025 – This policy resulted from the consolidation of former policy items #51.00 and #51.20, consequential to reformatting and renumbering policies in Chapter 7, *Protection of and Deductions from Benefits*.
July 4, 2025 − Housekeeping changes related to the reformatting and renumbering of Chapter 9, *Average Earnings*, of the *Rehabilitation Services & Claims Manual*, Volume II.
December 1, 2023 – Housekeeping amendment.
November 24, 2022 – Housekeeping changes consequential to implementing the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41).
January 1, 2021 – Housekeeping change made to cross-reference consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
January 1, 2015 – Consequential amendments were made arising from changes to Chapter 10, *Health Care, Rehabilitation Services & Claims Manual,* Volume II.
December 31, 2003 – Policy amended regarding references to benefits paid to surviving dependants, in accordance with the legislative changes in the *Skills Development and Labour Statutes Amendment Act*, 2003 (Bill 37 of 2003); Policy also amended regarding references to then sections 17 and 18 of the then *Act*, as well as dollar amounts in then sections 17, 18, and then Schedule C of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as it read immediately before June 30, 2002.

APPLICATION: Section A applies to all periodic payments made to workers and surviving dependants.
Section B applies to all dollar amounts in the *Act*.

RE:	Compensation on the Death of a Worker − Introduction	ITEM:	C8-52.00

BACKGROUND

1. Explanatory Notes

This policy provides an overview of compensation entitlement on the death of a worker.

2. The Act

Section 1, in part:

> **"family member"**, in relation to a worker, means the following:
>
> (a) a spouse, parent, grandparent, step-parent, child, grandchild, stepchild, sibling or half-sibling of the worker;
>
> (b) a person, whether related to the worker by blood or not, who stood in place of a parent of the worker or to whom the worker stood in place of a parent;
>
> ...

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] must be paid by the Board out of the accident fund.

Section 136(1):

> Compensation is payable under this Part [Part 4 – Compensation to Injured Workers and Their Dependants] in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment, if
>
> (a) as applicable,
>
> (i) the worker has an occupational disease that disables the worker from earning full wages at the work at which the worker was employed, or

(ii) the death of the worker is caused by an occupational disease, and

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

POLICY

Compensation is payable under the *Act* where the death of a worker arises out of and in the course of the worker's employment or is caused by an occupational disease that is due to the nature of any employment in which the worker was employed.

Compensation is payable to the worker's dependants or in some cases to non-dependent family members having a reasonable expectation of pecuniary benefit from the continuation of the life of the deceased worker.

Compensation on the death of a worker is normally based on the worker's average net earnings prior to the date of death. In addition, cost of living adjustments are made to payments and to the dollar amounts in the *Act*. Effective December 31, 2003, where a worker in receipt of a permanent disability benefits dies as a result of the compensable disability and compensation for one or more dependants is payable, no cost of living adjustment is applied in the 12 month period following the date of death.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Sections 134(1), 136(1), and Part 4, Division 5 – Compensation in Relation to Death of a Worker, of the *Act*.
CROSS REFERENCES:	Item C7-51.00, *Cost of Living Adjustments to Periodic Payments*; Chapter 9 − Average Earnings, of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. Replaced policy item #52.00 of the *Rehabilitation Services & Claims Manual,* Volume II.
APPLICATION:	This Item applies to the death of a worker on or after December 31, 2003.

RE:	Compensation on the Death of a Worker − Definitions − Meaning of "Dependant" and Presumptions of Dependency	ITEM:	C8-53.00

BACKGROUND

1. Explanatory Notes

This policy describes who is a "dependant" for the purposes of compensation as a result of a worker's death. It also describes the circumstances where it is presumed, without further investigation, that a spouse or child was a dependant of a worker at the date of the worker's death.

2. The Act

Section 1, in part:

"dependant"

(a) means

(i) a family member of the worker who was wholly or partly dependent on the worker's earnings at the time of the worker's death, or

(ii) a family member of the worker who, but for the worker's incapacity due to the accident or occupational disease, would have been wholly or partly dependent on the worker's earnings, and

(b) other than in the following sections, includes a spouse, child or parent of the worker who satisfies the Board that the spouse, child or parent had a reasonable expectation of pecuniary benefit from the continuation of the life of that worker:

(i) section 167 *[lump sum payment to dependent spouse or foster parent]*;

(ii) section 169 *[dependent spouse who is 50 years of age or older or is incapable of earning, no dependent children]*;

(iii) section 170 *[dependent spouse who is under 50 years of age and not incapable of earning, no dependent children]*;

(iv) section 171 *[dependent spouse and one or more dependent children]*;

(v) section 172 *[one or more dependent children but no dependent spouse]*;

(vi) section 173 *[dependent parents in addition to spouse or children]*;

(vii) section 174 *[no dependent spouse or children: compensation to other dependants]*;

(viii) section 178 *[dependent spouse living apart from worker at the date of death]*;

...

"family member", in relation to a worker, means the following:

(a) a spouse, parent, grandparent, step-parent, child, grandchild, stepchild, sibling or half-sibling of the worker;

(b) a person, whether related to the worker by blood or not, who stood in the place of a parent of the worker or to whom the worker stood in place of a parent;

...

Section 165, in part:

(1) In this Division:

"dependent spouse", in relation to a deceased worker means a surviving spouse of the worker who is a dependant of the worker;

…

(2) If 2 workers are spouses and both are contributing to the support of a common household, each is deemed to be a dependant of the other.

(3) If parents contribute to the support of a common household at which their children also reside, the children are deemed to be dependants of the parent whose death is compensable under this Part [Part 4 of the *Act* – Compensation in Relation to Death of a Worker].

POLICY

1. Meaning of Dependant

The term "dependant" means a family member of a worker who was wholly or partly dependent on the worker's earnings at the time of the worker's death, or a family member of the worker who, but for the worker's incapacity due to the accident or occupational disease would have been wholly or partly dependent on the worker's earnings. In certain limited situations, as discussed in Item C8-56.70, a spouse, parent, child, or other family member who satisfies the Board that they had a reasonable expectation of pecuniary benefit from the worker if the worker had not died, may also be entitled to compensation.

Section 1 of the *Act* defines who is a family member in relation to a worker.

Only the family members of a worker may be found to be the worker's dependants. Thus, a former spouse does not qualify as a dependant of a deceased worker because the former spouse is not considered a family member of the worker under the *Act*.

Dependency does not exist simply because the claimant is a family member of the worker. There must be evidence that, at the time of the worker's death, the claimant was actually wholly or partly dependent on the worker's earnings.

Except in respect of the provision discussed in Item C8-56.70, a reasonable expectation of pecuniary benefit from the continuation of the life of the worker is not itself sufficient to constitute dependency.

The above principles also apply where the claimant is a child. In the case of a child who was unborn at the date of the worker's death, once paternity is established, the fact that the worker would have been under an obligation to support the child is evidence to warrant an inference that that person would have supported the child, and should be accepted as proof of dependency unless it is controverted by evidence to the contrary. If it is found that the worker was supporting the mother at the time of death, that is also evidence from which an inference may be drawn that that person would have supported the child.

Dependency is determined at the date of death. Changes of circumstances after the death, for instance, the marriage of a child, do not affect the status of a person as a dependant.

2. Presumptions of Dependency

If two workers are spouses and both are contributing to the support of a common household, each is deemed to be a dependant of the other.

If parents contribute to the support of a common household at which their children also reside, the children are deemed to be dependants of the parent whose death is compensable.

For a common household to exist it is not necessary that there be a constant 24-hour-a-day presence by both parties in the house. There are many reasons why one party to a marriage would leave the house for different periods which would not affect the existence of the common household. However, this only applies when the absences are consistent with the normal continuation of the marriage. The common household will come to an end when there is some kind of separation of the parties which brings into question the continued existence of the marriage. For example, if one party deserts the other or, because of difficulties in the marital relationship, a separation agreement or court order comes into being.

A prospect of reconciliation is not sufficient to establish that a common household existed. This might indicate a possibility of the common household again coming into existence at a future time, but does not alter the fact that there was no such household in existence at the time of the worker's death.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Sections 1 and 165 of the *Act*.
CROSS REFERENCES:	Item C8-56.70, *Compensation on the Death of a Worker – Calculation of Compensation – Persons with a Reasonable Expectation of Pecuniary Benefit*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	June 1, 2024 − Housekeeping changes made to modernize terminology by removing gendered language. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. March 1, 2012 − Housekeeping changes made in accordance with legislative amendments to the then *Act*. November 24, 2011 − Housekeeping changes made in accordance with legislative amendments to the then *Act*. March 22, 2004 – Typographical correction made, not intended to change substantive decision-making. December 31, 2003 – This Item replaced policy items #54.00 and #54.10 of the *Rehabilitation Services & Claims Manual,* Volume II, to implement the legislative amendments contained in the *Skills Development and Labour Statutes Amendment Act*, 2003 (Bill 37 of 2003).
APPLICATION:	This Item applies to the death of a worker on or after December 31, 2003.

RE:	Compensation on the Death of a Worker − Definitions − Meaning of "Spouse"	ITEM:	C8-53.10

BACKGROUND

1. Explanatory Notes

This policy describes who is a "spouse" for the purposes of compensation as a result of a worker's death.

2. The Act

Section 1, in part:

> **"dependant"** – See Item C8-53.00.
>
> **"spouse"** means a person who
>
> (a) is married to another person, or
>
> (b) has lived with another person in a marriage-like relationship for
>
> (i) a period of at least 1 year, if the person has had a child with the other person, or
>
> (ii) a period of at least 2 years in any other case;
>
> **"surviving spouse"** means a person who was a spouse of a worker when the worker died;
>
> ...

Section 165, in part:

> (1) In this Division [Division 5 of Part 4 of the *Act* – Compensation in Relation to Death of Worker].
>
> …
>
> **"dependent spouse"**, in relation to a deceased worker, means a surviving spouse of the worker who is a dependant of the worker;
>
> …

POLICY

1. Meaning of Spouse

A "spouse" means a person who

(a) is married to another person, or

(b) has lived with another person in a marriage-like relationship for

(i) a period of at least 1 year, if the person has had a child with the other person, or

(ii) a period of at least 2 years in any other case.

The phrase "marriage-like relationship" is interpreted to mean a common-law relationship, and describes situations in which two people are living together in a regular and established way, sharing conjugal relations and a common household.

A person is not excluded from being a common-law spouse of one person simply because the person is legally married to another.

The phrase "had a child with the other person" means that children must be born of the relationship between the worker and the common-law spouse or be adopted by the worker and the common-law spouse. The fact that children have been brought into the relationship from a previous relationship is not sufficient. However, such children may have claims in their own right as children of the deceased, even if brought into the relationship by the common-law spouse.

2. Surviving Spouse

A surviving spouse is a person who was a spouse of a worker when the worker died. A surviving spouse may be a married spouse or a common-law spouse of a worker.

EFFECTIVE DATE: March 1, 2012
AUTHORITY: Section 1 of the *Act*.
CROSS REFERENCES: Item C8-53.20, *Compensation on the Death of a Worker Definitions – Meaning of "Child" or "Children"*;
Item C8-56.00, *Compensation on the Death of a Worker – Calculation of Compensation – Dependent Spouse with Children*;
Item C8-56.70, *Compensation on the Death of a Worker – Calculation of Compensation – Persons with a Reasonable Expectation of Pecuniary Benefit*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY: April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
March 1, 2012 − New Item consequential to the *Family Law Act* (Bill 16 of 2011), which introduced definitions of spouse and surviving spouse to then section 1 of the *Act*.

APPLICATION: This Item applies to the death of a worker that occurs on or after March 1, 2012.

RE:	Compensation on the Death of a Worker − Definitions − Meaning of "Child" or "Children"	ITEM:	C8-53.20

BACKGROUND

1. Explanatory Notes

This policy explains the meaning of "child" for the purposes of determining entitlement to compensation following the death of the worker.

2. The Act

Section 1, in part:

> **"family member"**, in relation to a worker, means the following:
>
> (a) a spouse, parent, grandparent, step-parent, child, grandchild, stepchild, sibling or half-sibling of the worker;
>
> (b) a person, whether related to the worker by blood or not, who stood in place of a parent of the worker or to whom the worker stood in place of a parent;
>
> **"surviving spouse"** means a person who was a spouse of a worker when the worker died;
>
> ...

Section 165:

> (1) In this Division [Division 5 of Part 4 of the *Act* – Compensation in Relation to Death of a Worker]:
>
> **"child"** in relation to a deceased worker, means a child of the worker who
>
> (a) is under 19 years of age, including a child who was not yet born at the date of the worker's death,
>
> (b) is under 25 years of age and regularly attends an academic, technical or vocational place of education,
>
> (c) is a child of any age who, at the date of the worker's death, had a physical or mental disability that resulted in the child being incapable of earning, or

(d) at the date of the worker's death was not a child described in paragraph (c) but became such a child before otherwise ceasing to be entitled to compensation under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants];

...

POLICY

1. Meaning of "Child" or "Children"

A "child" of the deceased worker includes a person to whom the worker stood in place of a parent at the date of the worker's death. "Child" also includes an unborn child of the deceased worker. These concepts are discussed below in Sections 2 and 3 of this Item.

To be eligible for compensation as a result of the death of a worker, a child must satisfy one of the four following requirements. The child must be a child of the worker who

(a) is under 19 years of age, including a child who was not yet born at the date of the worker's death,

(b) is under 25 years of age and regularly attends an academic, technical or vocational place of education,

(c) is a child of any age who, at the date of the worker's death had a physical or mental disability that resulted in the child being incapable of earning, or

(d) at the date of the worker's death was not a child described in paragraph (c) but became such a child before otherwise ceasing to be entitled to compensation.

2. Worker Stood in Place of a Parent to a Child

The decision of whether a deceased worker stood in place of a parent to a child will depend in each case, on the particular circumstances of the claim. Generally, the evidence will have to show that the worker acted as, and assumed the responsibility of, a parent of the child. Normally, the worker will have been living with and maintaining the child, but it may be possible to establish such a relationship even where they were not living in the same household.

The evidence must show that the relationship where the worker stood in place of a parent to the child continued to exist right up to the date of death. It is not sufficient simply to establish that such a relationship existed at some past time. There is no presumption under the *Act* that, once a situation where a worker stood in place of a

parent to a child is found to have existed, it must be deemed to have continued unless and until there is evidence to the contrary.

3. Unborn Children

Under section 165 of the *Act*, a "child" includes a child who was not yet born at the date of the worker's death. To be considered an unborn child of the deceased worker, the child must have been conceived before the worker's death. If the pregnancy occurs after the worker's death, for instance through scientific intervention, the unborn child will not be considered a "child" of the deceased worker for the purposes of compensation under the *Act*.

Compensation payable in respect of an unborn child of a deceased worker commences from the date of death of the worker, and not from the date of the child's birth. If the child is stillborn, the provision set out in Item C8-57.00 applies as from the date of birth.

Under the Canada Pension Plan, a surviving spouse who is pregnant at the date of the worker's death receives a pension for the child from the first day of the month in which the child is born. The amount of workers' compensation payments will be adjusted when the child is born according to the Canada Pension Plan benefits then being received.

4. Children with a Physical or Mental Disability

A child of the deceased worker is entitled to compensation at any age in two situations:

- if, at the date of the worker's death, the child had a "physical or mental" disability that results in the child being "incapable of earning"; or

- if the child becomes "incapable of earning" because of a physical or mental disability before otherwise ceasing to be entitled to compensation.

In these cases, "incapable of earning" means the person is not physically or mentally capable of independently supporting themselves financially. A person who has a physical or mental disability, but is capable of independently supporting themselves financially does not satisfy this definition of "child" under the *Act*. A temporary physical or mental incapacity to earn is not sufficient to determine that a person is a "child" for the purpose of receiving compensation for the death of a worker.

5. Regularly Attends an Academic, Technical or Vocational Place of Education

This Item applies to a child who has reached 19 years of age, but is under 25 years of age, and who regularly attends an academic, technical or vocational place of education.

There is no requirement that attendance at the place of education must be full time or at a certain time of day. For instance, a child who works during the day may attend school at night. However, this is subject to the nature of the course being taken. If, for example, all that is being done by the child is attending a single course, one night per week, which may lead to a degree in 10 years or so, it might be difficult to conclude that the child was "regularly attending" a place of education.

Correspondence courses taken at home are not sufficient. The only possible exception might be if the period of home study is temporary and the child intends to return shortly to a place of education.

Apprenticeships do not qualify since they involve practical work in a work place as opposed to attending a place of education.

When a child reaches 19 years of age, the surviving spouse and/or the child are contacted with regard to plans for continuing education. If the child plans to continue education, the child is advised that compensation will be paid until 25 years of age, including summer months, as long as the child pursues the education.

Temporary absences from school will not cause a discontinuation of compensation payments as long as the Board is satisfied that there is a clear intention to eventually return to the educational program. In the absence of fraud or misrepresentation, no overpayment will be declared if the child, in fact, does not return to school.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	Sections 1 and 165(1) of the *Act.*
CROSS REFERENCES:	Item C8-57.00, *Compensation on the Death of a Worker – Recalculation of Compensation on a Change in Circumstances*; Item C8-53.00, *Compensation on the Death of a Worker – Definitions – Meaning of Dependant and Presumptions of Dependency*; Item C8-56.00, *Compensation on the Death of a Worker – Calculation of Compensation – Dependent Spouse with Children*; Item C8-56.40, *Compensation on the Death of a Worker – Calculation of Compensation – Children*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	June 1, 2024 − Housekeeping changes made to modernize terminology by removing gendered language. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. November 24, 2011 − Housekeeping amendments made in accordance with legislative amendments to the then *Act.* June 30, 2002 – This Item replaced policy items #55.25, #58.10, #58.11, #58.12, #58.13, #58.14 of the *Rehabilitation Services & Claims Manual,* Volume II.
APPLICATION:	This Item applies to the death of a worker on or after June 30, 2002.

RE: Compensation on the Death of a Worker − Definitions − Meaning of "Federal Benefits" **ITEM: C8-53.30**

BACKGROUND

1. Explanatory Notes

This policy explains the meaning of "federal benefits". In certain situations, the *Act* directs that 50% of federal benefits payable for a dependent spouse and/or children be deducted from compensation payable to them.

2. The Act

Section 165(1), in part:

> **"federal benefits"** means the benefits paid for a dependant under the *Canada Pension Plan* as a result of a worker's death, other than the death benefit payable to the estate of a worker under section 57 *[death benefit]* of that Act.

POLICY

Meaning of "Federal Benefits"

The *Act* defines the term "federal benefits" as benefits paid for a dependant under the *Canada Pension Plan* ("CPP") as a result of a worker's death. This means the "survivor's pension" and/or "children's benefits" paid under the CPP. "Federal benefits" do not include the death benefit that is payable to a worker's estate under the CPP.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	Section 165(1) of the *Act*.
CROSS REFERENCES:	Item C8-56.00, *Compensation on the Death of a Worker – Calculation of Compensation – Dependent Spouse with Children*; Item C8-56.20, *Compensation on the Death of a Worker – Calculation of Compensation – Dependent Spouse with No Children*; Item C8-56.40, *Compensation on the Death of a Worker – Calculation of Compensation – Children*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 30, 2002 − Replaced policy item #55.24 of the *Rehabilitation*

Services & Claims Manual, Volume II.

APPLICATION: This Item applies to the death of a worker on or after June 30, 2002.

RE:	Compensation on the Death of a Worker – Funeral and Other Death Expenses	ITEM:	C8-54.00

BACKGROUND

1. Explanatory Notes

This policy establishes the amount the Board will pay for funeral and other death expenses following the death of a worker. It also describes who is eligible to receive payments for these expenses.

2. The Act

Section 166:

(1) The following apply if compensation is payable under this Part [Part 4 – Compensation to Injured Workers and Their Dependants] as the result of the death of a worker or of injury resulting in such death:

(a) in addition to any other compensation payable under this Division [Division 5 of Part 4 of the *Act* – Compensation in Relation to Death of Worker], the Board must pay an amount in respect of funeral and related expenses, as determined in accordance with the policies of the board of directors;

(b) the employer of the worker must bear the cost of transporting the body to the nearest business premises where funeral services are provided;

(c) if burial does not take place at the premises referred to in paragraph (b), the Board must pay the costs of any additional transportation, up to a maximum determined in accordance with the policies of the board of directors.

(2) No action for an amount greater than that established under subsection (1) lies in respect of the funeral, burial or cremation of the worker or related cemetery charges.

POLICY

1. Funeral and Other Death Expenses

If compensation is payable as the result of the death of a worker or of injury resulting in such death, in addition to any other compensation payable, the Board pays an amount in respect of funeral and related expenses. The maximum amount payable for funeral and related expenses is set out below.

The employer of the worker is required to bear the cost of transporting the body to the nearest business premises where funeral services are provided, and if burial does not take place at the nearest business premises where funeral services are provided, the Board may pay the cost of any additional transportation, up to the maximum set out below.

	Funeral and Related Expenses	Transportation of Body
January 1, 2025 – December 31, 2025	$11,456.68	$1,810.08
January 1, 2026 – December 31, 2026	$11,704.51	$1,849.23

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

Effective December 31, 2003, the above figures are adjusted annually on January 1 of each year. The percentage change in the consumer price index determined under section 333 of the *Act*, as described in Item C7-51.00, is used.

No action for an amount greater than that established by the above provisions lies in respect of the funeral, burial, or cremation of the worker or related cemetery charges.

2. Person to Whom Expenses are Paid

Payment of funeral and related expenses is made to the most eligible person or persons, as determined by the Board. In determining whom to pay, the Board considers who has incurred the cost of funeral and related expenses, or who has undertaken to meet those payments.

Where the funeral and related expenses are less than the maximum provided in this Item, the Board pays only the actual amount of funeral and related expenses.

Once the Board has paid out the maximum amount provided in this Item to one or more persons, the Board does not consider any other claims for funeral and related expenses.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Section 166 of the *Act*
CROSS REFERENCES:	Item C7-51.00, *Cost of Living Adjustments to Periodic Payments*, of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	December 1, 2025 − Housekeeping change to update internal cross-reference, consequential to reformatting and renumbering Chapter 7, *Protection of and Deductions from Benefits.* April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. December 31, 2003 − Replaced policy items #53.00 and #53.10, of the *Rehabilitation Services & Claims Manual,* Volume II.
APPLICATION:	This Item applies to the death of a worker on or after December 31, 2003.

RE:	Compensation on the Death of a Worker − Lump Sum Payment	ITEM:	C8-55.00

BACKGROUND

1. Explanatory Notes

This policy describes the provision of a lump sum payment to an eligible dependent spouse or foster parent.

2. The Act

Section 167:

> In addition to any other compensation provided, a dependent spouse or foster parent in Canada to whom compensation is payable is entitled to a lump sum of $3 456.92.

POLICY

Lump Sum Payment

A dependent spouse or foster parent in Canada to whom compensation is payable as a result of a worker's death is also entitled to a lump sum payment as follows:

January 1, 2025	—	December 31, 2025	$3,383.72
January 1, 2026	—	December 31, 2026	$3,456.92

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

Payment of this amount is made as soon as the claim is accepted.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Section 167 of the *Act*.
CROSS REFERENCES:	Item C7-51.00, *Cost of Living Adjustments to Periodic Payments*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. November 24, 2011 − Housekeeping amendments made in accordance with legislative amendments to the then *Act*. December 31, 2003 − Replaced policy item #55.10 of the *Rehabilitation Services & Claims Manual,* Volume II.
APPLICATION:	This Item applies to the death of a worker on or after December 31, 2003.

RE:	Compensation on the Death of a Worker – Calculation of Compensation – Dependent Spouse with Children	ITEM:	C8-56.00

BACKGROUND

1. Explanatory Notes

This policy describes how compensation as a result of a worker's death is calculated for a dependent spouse with dependent children.

2. The Act

Section 1, in part:

> **"dependant"** – See Item C8-53.00.
>
> **"surviving spouse"** means a person who was a spouse of a worker when the worker died;
>
> ...

Section 165:

> (1) In this Division [Division 5 of Part 4 of the *Act* – Compensation in Relation to Death of Worker]:
>
> **"child"**, in relation to a deceased worker, means a child of the worker who
>
> (a) is under 19 years of age, including a child who was not yet born at the date of the worker's death,
>
> (b) is under 25 years of age and regularly attends an academic, technical or vocational place of education,
>
> (c) is a child of any age who, at the date of the worker's death, had a physical or mental disability that resulted in the child being incapable of earning, or
>
> (d) at the date of the worker's death was not a child described in paragraph (c) but became such a child before otherwise ceasing to be entitled to compensation under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants];

"dependent spouse", in relation to a deceased worker, means a surviving spouse of the worker who is a dependant of the worker;

"federal benefits" means the benefits paid for a dependant under the *Canada Pension Plan* as a result of a worker's death, other than the death benefit payable to the estate of a worker under section 57 *[death benefit]* of that Act.

(2) If 2 workers are spouses and both are contributing to the support of a common household, each is deemed to be a dependant of the other.

(3) If parents contribute to the support of a common household at which their children also reside, the children are deemed to be dependants of the parent whose death is compensable under this Part [Part 4 – Compensation to Injured Workers and Their Dependants].

Section 168:

(1) Subject to subsection (2), if compensation is payable as the result of the death of a worker or of injury resulting in such death, the Board must pay compensation to the dependants of the deceased worker in accordance with this Division [Division 5 of Part 4 of the *Act* – Compensation in Relation to Death of Worker].

(2) Unless a shorter period applies under this Division [Division 5 of Part 4 of the *Act – Compensation in Relation to Death of Worker*], the Board must make periodic payments under this Division for the life of the person to whom the payment is to be made.

Section 171:

(1) This section applies if a deceased worker leaves a dependent spouse and one or more child dependants.

(2) Subject to subsection (4), if the dependants are a dependent spouse and one child dependant, the Board must make a monthly payment of an amount that, when combined with 50% of the federal benefits payable to or for the dependants referred to in subsection (1), would equal 85% of the monthly rate of compensation under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability.

(3) Subject to subsection (4), if the dependants are a dependent spouse and 2 or more child dependants, the Board must make a monthly payment of an amount that, when combined with 50% of the federal benefits payable to or for those dependants, would equal the total of

(a) the monthly rate of compensation under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability, and

(b) if there are more than 2 child dependants, $449.20 per month for each child dependant beyond that number.

(4) The minimum compensation payable under this section must be the compensation that would be payable if the compensation were calculated under this section in respect of a deceased worker with average earnings of $48 395.62 per year.

POLICY

This Item applies to a dependent spouse and one or more child dependants. A surviving spouse and children who were not dependent upon the worker's earnings at the time of the worker's death may be entitled to compensation under Item C8-56.70.

1. Calculation of Compensation – Dependent Spouse with One Child Dependant

The monthly payment for a dependent spouse with one child dependant is calculated as follows:

(I) The Board determines 85% of the monthly rate of compensation that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability, subject to the minimum provided in Section 4 of this Item.

(II) The Board then deducts an amount equal to 50% of the federal benefits payable to or for those dependants.

The example below describes the monthly payment that would be payable for a dependent spouse and one child dependant, where the worker died on April 6, 2020 with an average net earnings of $60,000 per year.

(I) The Board determines 85% of the monthly rate of compensation

A.	Monthly permanent total disability benefits rate at date of death	90% x $\frac{60,000}{12}$	=	4,500
B.	85% of A	85% of A	=	3,825
	Maximum compensation entitlement (Board and federal benefits)	85% x 4,500	=	3,825

(II) The Board deducts an amount equal to 50% of federal benefits

C.	Federal benefits for dependent spouse	CPP rate set each year	=	638.28
D.	Federal benefits for child dependant	1 x CPP rate set each year	=	255.03
E.	Total federal benefits (dependent spouse and child)	C + D (638.28+255.03)	=	893.31
F.	50% of total federal benefits	50% of E (50% x 893.31)	=	446.65
G.	Total Board monthly payments payable (B less F)	B − F 3,825 446.65	=	3,378.35

2. Calculation of Compensation – Dependent Spouse with Two or More Child Dependants

The monthly payment for a dependent spouse and two or more child dependants is calculated as follows:

(I) The Board adds:

(a) the entire monthly rate of compensation that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability, subject to the minimum provided in section 4 of this Item, and

(b) the following amount per month for each child dependant beyond two in number.

January 1, 2025	—	December 31, 2025	$439.69
January 1, 2026	—	December 31, 2026	$449.20

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

(II) The Board then deducts an amount equal to 50% of the federal benefits payable to or for those dependants.

The example below describes the monthly payment that would be payable for a dependent spouse and three child dependants, where the worker died on April 6, 2020, with an average net earnings of $60,000 per year.

(I) The Board determines 100% of the monthly rate of compensation, plus the additional amount for extra dependants

A.	Monthly permanent total disability benefits rate at date of death	90% x $\frac{60{,}000}{12}$	=	4,500
B.	Additional amount for third child dependant under section 171(3)(b)	See section 171(3)(b)	=	449.20
C.	Total monthly compensation rate (A plus B) and	A + B	=	4,949.20
	Maximum compensation entitlement (Board and federal benefits)	4,500 + 449.20	=	4,949.20

(II) The Board deducts an amount equal to 50% of federal benefits

D.	Federal benefits for dependent spouse	CPP rate set each year	=	638.28
E.	Federal benefits for child dependants	3 x CPP rate set each year (3 x 255.03)	=	765.09

F.	Total federal benefits (dependent spouse and children)	D + E	=	1,403.37
G.	50% of total federal benefits	50% x F (50% x 1,403.37)	=	701.69
H.	Total Board monthly payments payable (C less G)	C − G 4,949.20 701.69	=	4,247.51

3. Change in Federal Benefits

If the Board receives evidence of a change in a dependant's entitlement to federal benefits, the amount of federal benefits deducted from the compensation for that dependant is adjusted accordingly. For instance, if the Board receives evidence that children's benefits under the Canada Pension Plan have been terminated, the amount of federal benefits deducted from the compensation for that child will be adjusted. The adjustment takes effect as of the date of the change in federal benefits.

4. Minimum Monthly Payments

The minimum monthly payment under this Item must not be less than the amount that would be payable if, at the date of death, the deceased worker had the following average earnings:

January 1, 2025	—	December 31, 2025	$47,370.91
January 1, 2026	—	December 31, 2026	$48,395.62

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

5. Commencement of Compensation

Compensation under this Item commences on the day after the date of the worker's death.

6. Duration and Recalculation of Compensation

Compensation for a dependent spouse is payable for life.

Compensation for a dependent spouse with one or more child dependants is recalculated in accordance with Item C8-57.00 as each child ceases to meet the requirements, described in Item C8-53.20, to be eligible for compensation as a "child" of the deceased worker.

Compensation for a dependent child is recalculated under Item C8-57.00 if the dependent spouse dies before the children cease to meet the requirements, as described in Item C8-53.20, to be eligible for compensation as "children" of the deceased worker.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	Sections 165, 168, and 171 of the *Act*.
CROSS REFERENCES:	Item C8-53.00, *Compensation on the Death of a Worker – Definitions – Meaning of "Dependant" and Presumptions of Dependency*; Item C8-53.10, *Compensation on the Death of a Worker – Definitions – Meaning of "Spouse"*; Item C8-53.20, *Compensation on the Death of a Worker – Definitions – Meaning of "Child" or "Children"*; Item C8-53.30, *Compensation on the Death of a Worker – Definitions – Meaning of "Federal Benefits"*; Item C8-56.70, *Compensation on the Death of a Worker – Calculation of Compensation – Persons with a Reasonable Expectation of Pecuniary Benefit*; Item C8-57.00, *Compensation on the Death of a Worker – Recalculation of Compensation on a Change in Circumstances*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	September 1, 2024 – Housekeeping changes to correct figures used in examples. February 2022 − Housekeeping change. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. November 24, 2011 − Housekeeping amendments made in accordance with legislative amendments to the then *Act*. June 30, 2002 − Replaced policy items #55.00, #55.20, #55.21, #55.22, #55.26, #55.60 and #61.60 of the *Rehabilitation Services & Claims Manual,* Volume II.
APPLICATION:	This Item applies to the death of a worker on or after June 30, 2002.

RE:	Compensation on the Death of a Worker – Calculation of Compensation – Dependent Spouse with No Children	ITEM:	C8-56.10

BACKGROUND

1. Explanatory Notes

This policy describes how compensation as a result of a worker's death is calculated for a dependent spouse with no dependent children.

2. The Act

Section 1, in part:

> **"dependant"** – See Item C8-53.00.
>
> **"surviving spouse"** means a person who was a spouse of a worker when the worker died;
>
> ...

Section 165, in part:

> (1) In this Division [Division 5 of Part 4 of the *Act* – Compensation in Relation to Death of Worker]:
>
> …
>
> **"dependent spouse"**, in relation to a deceased worker, means a surviving spouse of the worker who is a dependant of the worker;
>
> **"federal benefits"** means the benefits paid for a dependant under the *Canada Pension Plan* as a result of a worker's death, other than the death benefit payable to the estate of a worker under section 57 *[death benefit]* of that Act.
>
> (2) If 2 workers are spouses and both are contributing to the support of a common household, each is deemed to be a dependant of the other.
>
> (3) If parents contribute to the support of a common household at which their children also reside, the children are deemed to be dependants of the parent whose death is compensable under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants].

Section 169:

(1) This section applies if

(a) a deceased worker leaves a dependent spouse but does not leave any child dependants, and

(b) at the date of the worker's death, the dependent spouse

(i) was 50 years of age or older, or

(ii) had a physical or mental disability that resulted in the spouse being incapable of earning.

(2) Subject to subsection (3), the Board must make a monthly payment of an amount that, when combined with 50% of the federal benefits payable to or for that dependent spouse, would equal 60% of the monthly rate of compensation under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] that would have been payable if the deceased worker had, at the date of the worker's death, sustained a permanent total disability.

(3) A monthly payment under this section must not be less than $1 451.63.

Section 170:

(1) This section applies if

(a) a deceased worker leaves a dependent spouse but does not leave any child dependants, and

(b) at the date of the worker's death, the dependent spouse

(i) was under 50 years of age, and

(ii) did not have a physical or mental disability that resulted in the spouse being incapable of earning.

(2) Subject to subsection (3), the Board must make a monthly payment of an amount that, when combined with 50% of the federal benefits payable to or for the dependent spouse, would equal the product of

(a) the percentage determined by subtracting 1% from 60% for each year that the age of the dependent spouse, at the date of the worker's death, is under 50 years of age, and

(b) the monthly rate of compensation under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability.

(3) The percentage determined under subsection (2)(a) must not be less than 30%, and a monthly payment under this section must not be less than $1 451.63.

Section 187:

(1) This section applies if, at the date of a worker's death, a dependent spouse of the worker does not have a physical or mental disability that results in the spouse being incapable of earning, but does have a disability that results in a substantial impairment of earning capacity.

(2) The Board may, having regard to the degree of disability or the extent of impairment of earning capacity, pay the spouse a proportion of the compensation that would have been payable if the spouse had the incapacity referred to in subsection (1).

POLICY

This Item applies where there are no dependent children, but there is a dependent spouse at the time of the worker's death. A surviving spouse who was not a dependent spouse may be entitled to compensation under Item C8-56.70.

1. Meaning of Having a "Physical or Mental Disability that Resulted in the Dependent Spouse Being Incapable of Earning"

Being "physically or mentally incapable of earning" means the dependent spouse is not capable of independent financial support. A dependent spouse who has a physical or mental disability, but is capable of independent financial support is not entitled to compensation under section 169. A temporary physical or mental incapacity to earn is not sufficient to entitle a dependent spouse to compensation under section 169.

The Board may pay compensation to a dependent spouse under section 187 if, at the date of a worker's death a dependent spouse does not have a physical or mental disability that results in the dependent spouse being incapable of earning, but does have a disability that results in a substantial impairment of earning capacity. The Board may, having regard to the degree of disability or the extent of impairment of earning capacity, pay the dependent spouse a proportion of the compensation that would have been payable under section 169.

2. Calculation of Compensation – Dependent Spouse 50 Years of Age or Older or Incapable of Earning as a Result of Physical or Mental Disability

The monthly payment for a dependent spouse who, at the date of the worker's death, is either:

- 50 years of age or over, or
- has a physical or mental disability that results in the spouse being incapable of earning,

is calculated as the difference between:

(a) 60% of the monthly rate of compensation that would have been payable if the deceased worker had, at the date of the worker's death, sustained a permanent total disability, and

(b) 50% of the federal benefits payable to or for the dependent spouse.

The monthly payment is subject to the minimum amount provided in Section 5 of this Item.

3. Calculation of Compensation – Dependent Spouse under 50 Years

The monthly payment for a dependent spouse who, at the date of the worker's death, is under 50 years of age, and does not have a physical or mental disability that results in the spouse being incapable of earning, is calculated as follows:

(I) The Board multiplies:

(a) the percentage determined by subtracting one percentage point from 60%, to a minimum of 30%, for each year that the age of the dependent spouse, at the date of the worker's death, is under 50 years of age, by

(b) the monthly rate of compensation that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability.

(II) The Board then deducts an amount equal to 50% of the federal benefits payable to or for the dependent spouse from the product determined above.

The monthly payment is subject to the minimum amount provided in Section 5 of this Item.

When determining the percentage under (I)(a) above, the Board does not round up the age of the dependent spouse to the nearest whole number. For instance, a dependent spouse who is 35 years and 11 months is considered 35, not 36, for the purpose of determining the percentage to use in establishing compensation.

The example below describes the monthly payment that would be payable for a dependent spouse who, at the date of the worker's death, has no dependent children, is 35 years old, where the worker died on April 6, 2020, with an average net earnings of $60,000 per year.

(I) The Board determines the percentage to apply to the monthly rate of compensation

A.	Determination of percentage based on the dependent spouse's age	50 - 35	=	15%
	Relevant percentage	60% - 15%	=	45%

(II) The Board applies the age percentage to the monthly rate of compensation

B.	Monthly permanent total disability benefits rate at date of death	90% x $\frac{60{,}000}{12}$	=	4,500
C.	Product of percentage and monthly permanent total disability benefits rate (A times B), which is maximum compensation entitlement (Board and federal benefits)	45% x 4,500	=	2,025
			=	2,025

(III) The Board deducts an amount equal to 50% of federal benefits

D.	50% of federal benefits			
	Federal benefits for dependent spouse	CPP rate set each year	=	638.28
	50% of federal benefits	50% x 638.28	=	319.40

E.	Total Board monthly payments payable (C less D)	C 2,025	−	D 319.40	=	1,705.60

4. Change in Federal Benefits

If the Board receives evidence of a change in the entitlement of a dependent spouse to federal benefits, the amount of federal benefits deducted from the compensation for that dependant is adjusted accordingly. The adjustment takes effect as of the date of the change in federal benefits.

5. Minimum Monthly Payments

The minimum monthly payment for a dependent spouse under this Item is as follows:

January 1, 2025	—	December 31, 2025	$1,420.89
January 1, 2026	—	December 31, 2026	$1,451.63

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

The minimum monthly payment is the actual minimum paid by the Board. Federal benefits are not deducted from this minimum amount.

6. Commencement of Compensation

Compensation under this Item commences on the day after the date of the worker's death.

7. Duration and Recalculation of Compensation

Compensation for a dependent spouse is payable for life.

The amount of compensation payable for a dependent spouse who, at the date of the worker's death, had a physical or mental disability that resulted in the spouse being incapable of earning is recalculated in accordance with Item C8-57.00 if the dependent spouse ceases to have that disability.

EFFECTIVE DATE: June 30, 2002
AUTHORITY: Sections 169 and 170 of the *Act*.

CROSS REFERENCES:

Item C8-53.00, *Compensation on the Death of a Worker – Definitions – Meaning of "Dependant" and Presumptions of Dependency*;
Item C8-53.10, *Compensation on the Death of a Worker – Definitions – Meaning of "Spouse"*;
Item C8-53.20, *Compensation on the Death of a Worker – Definitions – Meaning of "Child" or "Children"*;
Item C8-53.30, *Compensation on the Death of a Worker – Definitions – Meaning of "Federal Benefits"*;
Item C8-56.70, *Compensation on the Death of a Worker – Calculation of Compensation – Persons with a Reasonable Expectation of Pecuniary Benefit*;
Item C8-57.00, *Compensation on the Death of a Worker – Recalculation of Compensation on a Change in Circumstances*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:

September 1, 2024 – Housekeeping changes to correct figures used in examples.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
November 24, 2011 − Housekeeping amendments made in accordance with legislative amendments to the then *Act*.
June 30, 2002 − Replaced policy items #55.23, #55.30, #55.31, #55.32 and #55.33 of the *Rehabilitation Services & Claims Manual,* Volume II.

APPLICATION:

This Item applies to the death of a worker on or after June 30, 2002.

RE:	**Compensation on the Death of a Worker − Calculation of Compensation − Spouse Separated from Deceased Worker**	**ITEM: C8-56.20**

BACKGROUND

1. Explanatory Notes

This policy describes how compensation as a result of a worker's death is calculated for a separated dependent spouse and any dependent children living with that spouse.

2. The Act

Section 178:

(1) This section applies if

(a) compensation is payable under this Division [Division 5 of Part 4 of the *Act* – Compensation in Relation to Death of Worker] in relation to a worker's death, and

(b) at the date of death, the worker and a dependent spouse of the worker were living separate and apart.

(2) If, at the date of the worker's death, there was in force a court order or separation agreement providing periodic payments for support of the dependent spouse, or children living with that spouse,

(a) no compensation under sections 169 to 171 *[compensation to dependent spouse or to dependent spouse and child or children]* is payable to the spouse or children living with the spouse, and

(b) subject to subsection (5), the Board must make monthly payments in respect of that spouse and those children equal to the periodic payments due under the order or agreement.

(3) Subject to subsection (5), if

(a) there was no court order or separation agreement described in subsection (2) in force at the date of the worker's death, and

(b) the worker and dependent spouse were separated, with the intention of living separate and apart, for a period of 3 months or longer preceding that date,

the Board must make monthly payments up to the level of support the Board considers the spouse and children would have been likely to receive from the worker if the death had not occurred.

(4) Subject to subsection (5), if

(a) there was no court order or separation agreement described in subsection (2) in force at the date of the worker's death, and

(b) the worker and dependent spouse were living separate and apart for a period of less than 3 months preceding that date,

compensation is payable as provided in sections 169 to 176 *[rules respecting specific compensation payment]*.

(5) Compensation payable under this section must not be greater than the compensation that would have been payable under sections 169 to 176 if there had been no separation.

POLICY

This Item applies where the worker and dependent spouse, though still married, were living separate and apart at the date of the worker's death. It also applies to any dependent children of the deceased worker who were living with the separated dependent spouse at the time of the worker's death.

A spouse, or a child of the deceased worker living with that spouse, who was not wholly or partly dependent on the worker's earnings at the time of the worker's death is not entitled to compensation under this Item. The spouse or child may, however, be entitled under Item C8-56.70.

A divorced spouse is not eligible for compensation as a result of the worker's death. A divorce does not, however, affect the claim of any children of the marriage, who may be eligible for compensation under another Item in this chapter.

1. Calculation of Compensation – Court Order or Separation Agreement

If, at the date of the worker's death, a court order or separation agreement was in force providing periodic payments for support of the dependent spouse, or children living with that spouse, monthly compensation equal to the payments due under that order or agreement are payable.

Section 178(5) of the *Act* provides that compensation must not be greater than the compensation that would have been payable under the *Act* if the worker and spouse had not been separated at the date of the worker's death. As a result, the terms of the

court order or separation agreement will be followed provided they do not result in a higher amount of compensation than would be otherwise payable under sections 169 to 176 of the *Act* if there had been no separation.

It is irrelevant whether the worker was actually meeting their obligations under the court order or separation agreement at the date of death. However, if the worker was in arrears of support payments at the date of death, the Board will not pay compensation to cover the amount in arrears.

2. Calculation of Compensation – No Court Order or Separation Agreement

If, at the date of the worker's death, there was no court order or separation agreement in force providing payments for support of the dependent spouse, or children living with the spouse, the length of time during which the worker and spouse had been separated is considered as described below.

2.1 Separation of Three Months or Longer – No Court Order or Separation Agreement

If, at the date of death, the worker and dependent spouse had been separated for three or more months, the Board considers whether the parties intended to live separate and apart. The intention to live separate and apart is discussed below in Section 2.1.1 of this Item.

If it is found that, at the date of death, the parties did not intend to live separate and apart, section 178 of the *Act* does not apply and monthly payments are calculated as if there had been no separation.

If it is found that, at the date of death, the parties did intend to live separate and apart, monthly payments are based on the amount that the Board considers the spouse and children would have been likely to receive from the worker if the death had not occurred. However, compensation must not be greater than the compensation that would have been payable under sections 169 to 176 of the *Act* if there had been no separation.

2.1.1 Determination of Intention of Living Separate and Apart

Whether the worker and dependent spouse were separated with the "intention" of living separate and apart requires an examination of all the circumstances to determine whether the geographical separation is consistent with the normal continuation of the marriage, or whether these circumstances bring into question the continued existence of the marriage. The presence or absence of this mental element concerning the status of the relationship should be assessed both on an objective and subjective basis, rather than being solely based on the subjective views of the parties to the marriage.

The question is whether, on the basis of all the evidence, the parties either treated the marriage as being at an end or, alternatively, whether it may be concluded on an objective basis that the marriage had no continuing existence.

It would be sufficient to support a conclusion that the parties were living separate and apart if one party (not necessarily both) treated the marriage as being at an end. Also, it could be concluded on an objective basis that the parties were living separate and apart, notwithstanding the subjective belief of both parties that the marriage was continuing. This might be the case if the separation was for an indefinite period and there was no reasonable prospect of their being reunited in the foreseeable future. It might be considered that they had at least reconciled themselves to this situation, notwithstanding the subjective continuance of the marriage relationship. On the other hand, if the parties viewed themselves as continuing in their marriage and intended to reunite, and it was considered that this would occur in the reasonably foreseeable future, then it might be concluded that they were not living separate and apart.

It would not normally be considered that the parties were living separate and apart in circumstances where a period of temporary separation was necessitated by the worker's employment.

2.2 Separation of Less than Three Months – No Court Order or Separation Agreement

If, at the date of death, the worker and dependent spouse had been living separate and apart for a period of less than 3 months, compensation is calculated under sections 169 to 176 of the *Act* [rules respecting specific compensation payment] as if there had been no separation.

3. Lump Sum Payment

The full amount of the lump sum provided for in Item C8-55.00 is payable to a dependent spouse, in Canada, who receives compensation under this Item.

4. Commencement of Compensation

Compensation under this Item commences on the day after the date of the worker's death.

5. Duration of Compensation

Compensation for a separated dependent spouse under this Item are for life, unless the terms of a court order or separation agreement specify otherwise. Where there is no court order or separation agreement, compensation for a separated dependent spouse under this Item are for life, unless the Board determines the worker would have provided payments for a lesser period of time.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	Section 178 of the *Act*.
CROSS REFERENCES:	Item C8-53.00, *Compensation on the Death of a Worker – Definitions – Meaning of "Dependant" and Presumptions of Dependency*; Item C8-53.20, *Compensation on the Death of a Worker – Definitions – Meaning of "Child" or "Children"*; Item C8-55.00, *Compensation on the Death of a Worker – Lump Sum Payment*; Item C8-56.00, *Compensation on the Death of a Worker – Calculation of Compensation – Dependent Spouse with Children*; Item C8-56.10, *Compensation on the Death of a Worker – Calculation of Compensation – Dependent Spouse with No Children*; Item C8-56.30, *Compensation on the Death of a Worker – Calculation of Compensation – Common Law Relationships*; Item C8-56.40, *Compensation on the Death of a Worker – Calculation of Compensation – Children*; Item C8-56.70, *Compensation on the Death of a Worker – Calculation of Compensation – Persons with a Reasonable Expectation of Pecuniary Benefit*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	June 1, 2024 − Housekeeping changes made to modernize terminology by removing gendered language. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 30, 2002 − Replaced policy item #55.40 of the *Rehabilitation Services & Claims Manual,* Volume II.
APPLICATION:	This Item applies to the death of a worker on or after June 30, 2002.

RE:	Compensation on the Death of a Worker – Calculation of Compensation – Common Law Relationships	ITEM:	C8-56.30

BACKGROUND

1. Explanatory Notes

This policy describes how compensation as a result of a worker's death is calculated for a dependent spouse who was a common law spouse of the worker at the time the worker died.

2. The Act

Section 1, in part:

> **"dependant"** – See Item C8-53.00.
>
> **"spouse"** means a person who
>
> (a) is married to another person, or
>
> (b) has lived with another person in a marriage-like relationship for
>
> (i) a period of at least 1 year, if the person has had a child with the other person, or
>
> (ii) a period of at least 2 years in any other case;
>
> **"surviving spouse"** means a person who was a spouse of a worker when the worker died;
>
> ...

Section 165, in part:

> (1) In this Division [Division 5 of Part 4 of the *Act* – Compensation in Relation to Death of Worker]:
>
> …
>
> **"dependent spouse"**, in relation to a deceased worker, means a surviving spouse of the worker who is a dependent of the worker;
>
> ...

Section 179:

(1) Subject to subsection (2), compensation under this Division [Division 5 of Part 4 of the *Act* – Compensation in Relation to Death of a Worker] is payable to a worker's surviving spouse described in paragraph (b) *[marriage-like relationship]* of the definition of "spouse" in section 1, only if the worker was living with and contributing to the support and maintenance of that spouse immediately before the worker's death.

(2) Subsection (1) does not apply in relation to compensation that is payable under section 178(2) or (3) *[payment in relation to court order or separation agreement]*.

Section 180:

(1) This section applies if a deceased worker has left both

(a) a dependent spouse who is a spouse described in paragraph (a) *[spouse by marriage]* of the definition of "spouse" in section 1 from whom, at the date of death, the worker was living separate and apart, and

(b) a spouse described in paragraph (b) *[marriage-like relationship]* of that definition with whom the worker was living, and to whose support and maintenance the worker was contributing, immediately before the worker's death.

(2) If there is a difference between

(a) the amount of compensation payable to the spouse referred to in subsection (1)(a) *[spouse by marriage]* by reason of the separation, and

(b) the amount of compensation that would have been payable to that spouse if the spouse and the worker had not been living separate and apart,

the Board may pay compensation, up to the amount of the difference, to the spouse referred to in subsection (1)(b) *[marriage-like relationship]*.

POLICY

1. Compensation Payable to a Common Law Spouse

Compensation under this Item is payable to a common law spouse only if the worker was living with and contributing to the support and maintenance of the common law spouse immediately prior to the worker's death. However, where there was a court order or separation agreement in force at the date of the worker's death, or if the worker and dependent common law spouse were separated with the intention of living separate and apart, for a period of 3 months or longer preceding the date of the worker's death, the limitation of section 179(1) does not apply.

The amount of compensation that may be payable to a common law surviving spouse is dependent on the existence of a married dependent spouse, from whom the worker was living separate and apart at the worker's date of death.

If, a worker left both:

(a) a dependent married spouse from whom, at the date of death, the worker was living separate and apart; and

(b) a common law spouse, with whom the worker was living, and contributing to the support of, immediately before the worker's death; and

(c) there is a difference between the amount of compensation payable to the married spouse referred to in (a) above, under Item C8-56.20, by reason of the separation, and the amount of compensation that would have been payable to that spouse, if that spouse and the worker had not been living separate and apart;

then the Board may pay compensation to the common law spouse, up to the amount of the difference.

2. Commencement of Compensation

Compensation under this Item commences on the day after the date of the worker's death.

3. Duration of Compensation

Compensation for a common law dependent spouse is payable for life. Compensation is not affected if the common law dependent spouse remarries.

EFFECTIVE DATE:	March 1, 2012
AUTHORITY:	Sections 179 and 180 of the *Act*.
CROSS REFERENCES:	Item C8-53.00, *Compensation on the Death of a Worker – Definitions – Meaning of "Dependant" and Presumptions of Dependency*; Item C8-53.10, *Compensation on the Death of a Worker – Definitions – Meaning of "Spouse"*; Item C8-53.20, *Compensation on the Death of a Worker – Definitions – Meaning of "Child" or "Children"*; Item C8-55.00, *Compensation on the Death of a Worker – Lump Sum Payment*; Item C8-56.00, *Compensation on the Death of a Worker – Calculation of Compensation – Dependent Spouse with Children*; C8-56.10, *Compensation on the Death of a Worker – Calculation of Compensation – Dependent Spouse with No Children*; Item C8-56.20, *Compensation on the Death of a Worker – Calculation of Compensation – Spouse Separated from Deceased Worker*; C8-56.70, *Compensation on the Death of a Worker – Calculation of Compensation – Persons with a Reasonable Expectation of Pecuniary Benefit*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. March 1, 2012 − This Item was amended to update then sections 17(11) and 17(12), and to make other amendments in accordance with legislative changes to the then *Act*, arising from the *Family Law Act* (Bill 16 of 2011). The application statement providing that this Item applies to the death of a worker on or after December 31, 2003, was also changed on March 1, 2012 in accordance with the application of the Bill 16 amendments. November 24, 2011 − Housekeeping amendments made in accordance with legislative amendments to the then *Act*. June 30, 2002 − Replaced policy items #56.00 to #56.40 of the *Rehabilitation Services & Claims Manual,* Volume II.
APPLICATION:	This Item applies to the death of a worker that occurs on or after March 1, 2012.

RE:	Compensation on the Death of a Worker − Calculation of Compensation − Children	ITEM:	C8-56.40

BACKGROUND

1. Explanatory Notes

This policy describes how compensation as a result of a worker's death is calculated for dependent children.

2. The Act

Section 1, in part:

> **"surviving spouse"** means a person who was a spouse of a worker when the worker died;
>
> ...

Section 165:

> See Item C8-56.00.

Section 168:

> (1) Subject to subsection (2), if compensation is payable as the result of the death of a worker or of injury resulting in such death, the Board must pay compensation to the dependants of the deceased worker in accordance with this Division [Division 5 of Part 4 of the *Act* – Compensation in Relation to Death of Worker].
>
> (2) Unless a shorter period applies under this Division, the Board must make periodic payments under this Division for the life of the person to whom the payment is to be made.

Section 172:

> (1) This section applies if a deceased worker leaves no dependent spouse eligible for monthly payments under this Division [Division 5 of Part 4 of the *Act* – Compensation in Relation to Death of a Worker] but does leave one or more child dependants.

(2) Subject to subsection (5), if there is one child dependant, the Board must make a monthly payment of an amount that, when combined with 50% of the federal benefits to or for that child, would equal 40% of the monthly rate of compensation under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability.

(3) Subject to subsection (5), if there are more than 2 child dependants, the Board must make a monthly payment of an amount that, when combined with 50% of the federal benefits payable to or for those children, would equal 50% of the monthly rate of compensation under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability.

(4) Subject to subsection (5), if there are more than 2 child dependants, the Board must make a monthly payment of an amount that, when combined with 50% of the federal benefits payable to or for those children, would equal the total of

(a) 60% of the monthly rate of compensation under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability, and

(b) if there are more than 3 child dependants, $449.20 per month for each child beyond that number.

(5) The minimum compensation payable under this section must be the compensation that would be payable if the compensation were calculated under this section in respect of a deceased worker with average earnings of $48 395.62 per year.

POLICY

Children who were not wholly or partly dependent on the worker's earnings at the time of the worker's death are not entitled to compensation under this Item. They may, however, be entitled under Item C8-56.70.

1. Calculation of Compensation – Where there is a Dependent Spouse

If there is a dependent spouse eligible for periodic payments, the child dependent's compensation is calculated in conjunction with that of the dependent spouse under Items C8-56.00, C8-56.20 or C8-56.30. With one exception, this is so whether the child dependants live with the dependent spouse or not. Where they live apart, the apportionment provisions described in Item C8-58.00 may be applied to the compensation. The exception involves Item C8-56.20, which applies to child dependants only when they are living with the separated spouse at the date of the worker's death.

If there is a dependent spouse and one or more dependent children, and the dependent spouse subsequently dies, compensation for the dependent children is recalculated under Item C8-57.00.

2. Calculation of Compensation – Where there is no Dependent Spouse

If there is no dependent spouse or common law dependent spouse eligible for monthly payments under Division 5 of Part 4 of the *Act*, compensation for any dependent children is calculated as described below.

2.1 One Child Dependant

The monthly payment for one child dependant is calculated as the difference between:

(a) 40% of the monthly rate of compensation that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability; and

(b) 50% of the federal benefits payable to or for that child.

2.2 Two Child Dependants

The monthly payment for two child dependants is calculated as the difference between:

(a) 50% of the monthly rate of compensation that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability; and

(b) 50% of the federal benefits payable to or for those children.

2.3 More Than Two Child Dependants

The monthly payment for more than two child dependants is calculated as follows:

(I) The Board adds:

(a) 60% of the monthly rate of compensation that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability; and

(b) if there are more than 3 child dependants, the following amount per month for each child beyond that number:

January 1, 2025	—	December 31, 2025	$439.69
January 1, 2026	—	December 31, 2026	$449.20

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

(II) The Board then deducts an amount equal to 50% of the federal benefits payable to or for those children from the amount determined above.

3. Change in Federal Benefits

If the Board receives evidence of a change in a child dependant's entitlement to federal benefits, the amount of federal benefits deducted from the compensation for that child is adjusted accordingly. For instance, if the Board receives evidence that a child's benefits under the Canada Pension Plan have been terminated, the amount of federal benefits deducted from the compensation for that child will be adjusted. The adjustment takes effect as of the date of the change in federal benefits.

4. Minimum Monthly Payments

The minimum monthly payment under this Item must not be less than the amount that would be payable if, at the date of death, the deceased worker had the following average earnings:

January 1, 2025	—	December 31, 2025	$47,370.91
January 1, 2026	—	December 31, 2026	$48,395.62

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

5. Commencement of Compensation

Compensation under this Item commences on the day after the date of the worker's death.

6. Recalculation of Compensation

Compensation for child dependants is recalculated in accordance with Item C8-57.00 as each child ceases to meet the requirements, described in Item C8-53.20, to be eligible for compensation as a "child" of the deceased worker.

7. Foster Parents

Where a foster parent assumes responsibility for the care and maintenance of a deceased worker's child dependants, the Board may pay compensation to the foster parent and children under Item C8-56.50. If the Board pays compensation under Item C8-56.50, no compensation is provided for the child or children under this Item.

EFFECTIVE DATE: June 30, 2002
AUTHORITY: Section 172 of the *Act*.
CROSS REFERENCES:
Item C8-53.00, *Compensation on the Death of a Worker – Definitions – Meaning of "Dependant" and Presumptions of Dependency*;
Item C8-53.10, *Compensation on the Death of a Worker – Definitions – Meaning of "Spouse"*;
Item C8-53.20, *Compensation on the Death of a Worker – Definitions – Meaning of "Child" or "Children"*;
Item C8-53.30, *Compensation on the Death of a Worker – Definitions – Meaning of "Federal Benefits"*;
Item C8-56.00, *Compensation on the Death of a Worker – Calculation of Compensation – Dependent Spouse with Children*;
Item C8-56.20, *Compensation on the Death of a Worker – Calculation of Compensation – Spouse Separated from Deceased Worker*;
Item C8-56.30, *Compensation on the Death of a Worker – Calculation of Compensation – Common Law Relationships*;
Item C8-56.50, *Compensation on the Death of a Worker – Calculation of Compensation – Foster Parents*;
Item C8-56.70, *Compensation on the Death of a Worker – Calculation of Compensation – Persons with a Reasonable Expectation of Pecuniary Benefit*;
Item C8-57.00, *Compensation on the Death of a Worker – Recalculation of Compensation on a Change in Circumstances*;
Item C8-58.00, *Compensation on the Death of a Worker – Apportionment of Compensation,* of the *Rehabilitation*

HISTORY:

Services & Claims Manual, Volume II.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
March 1, 2012 − Housekeeping amendments made in accordance with legislative amendments to the then *Act*.
November 24, 2011 − Housekeeping amendments made in accordance with legislative amendments to the then *Act*.
June 30, 2002 − Replaced policy items #58.00, #58.21 and #58.22 of the *Rehabilitation Services & Claims Manual,* Volume II.

APPLICATION:

This Item applies to the death of a worker on or after June 30, 2002.

RE:	Compensation on the Death of a Worker − Calculation of Compensation − Foster Parents	ITEM:	C8-56.50

BACKGROUND

1. Explanatory Notes

This policy describes the calculation of compensation for the foster parent of a deceased worker's dependent child or children.

2. The Act

Section 176:

(1) This section applies if

(a) a deceased worker

(i) leaves a child or children entitled to compensation under this Division [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants], and

(ii) either leaves no dependent spouse or the dependent spouse subsequently dies,

(b) the Board considers it desirable to continue the existing household, and

(c) a suitable person acts as a foster parent in keeping up the household and taking care of and maintaining the child or children, in a manner satisfactory to the Board.

(2) The same compensation is payable to the foster parent and children as would have been payable to a dependent spouse and child dependants, and the compensation must continue as long as the conditions described in subsection (1) continue.

POLICY

Foster Parents

If the worker leaves a dependent child or children entitled to compensation under Division 5 of Part 4 of the *Act*, but no dependent spouse, or the dependent spouse

subsequently dies, the Board may consider it desirable to continue the existing household. If a suitable person acts as a foster parent in keeping up the household and taking care of and maintaining the children, in a manner satisfactory to the Board, the same compensation is payable to the foster parent and children as would have been payable to a dependent spouse and child dependants under Item C8-56.00. The compensation continues as long as the conditions continue.

A foster parent means a person who assumes responsibility for the care and maintenance of a dependent child or children. For the purposes of section 176 of the *Act*, a foster parent may include a natural parent who did not have physical custody of the child or children at the time of the workplace fatality.

The compensation includes the lump sum payable to the dependent spouses referred to in Item C8-55.00.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Section 176 of the *Act*.
CROSS REFERENCES:	Item C8-53.00, *Compensation on the Death of a Worker – Definitions – Meaning of "Dependant" and Presumptions of Dependency*; Item C8-53.20, *Compensation on the Death of a Worker – Definitions – Meaning of "Child" or "Children"*; Item C8-55.00, *Compensation on the Death of a Worker – Lump Sum Payment*; Item C8-56.00, *Compensation on the Death of a Worker – Calculation of Compensation – Dependent Spouse with Children*; Item C8-57.00, *Compensation on the Death of a Worker – Recalculation of Compensation on a Change in Circumstances*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. November 24, 2011 − Housekeeping amendments made in accordance with legislative amendments to the then *Act*. December 31, 2003 − Replaced policy item #57.00 of the *Rehabilitation Services & Claims Manual,* Volume II.
APPLICATION:	This Item applies to the death of a worker on or after December 31, 2003.

RE:	Compensation on the Death of a Worker − Calculation of Compensation – Dependent Parents and Other Dependants	ITEM:	C8-56.60

BACKGROUND

1. Explanatory Notes

This policy describes the calculation of compensation for dependent parents and "other dependants" of a deceased worker.

2. The Act

Section 1, in part:

> **"family member"**, in relation to a worker, means the following:
>
> (a) a spouse, parent, grandparent, step-parent, child, grandchild, stepchild, sibling or half-sibling of the worker;
>
> (b) a person, whether related to the worker by blood or not, who stood in place of a parent of the worker or to whom the worker stood in place of a parent;
>
> …

Section 173:

> (1) This section applies if a deceased worker
>
> (a) leaves either a dependent spouse or one or more child dependants entitled to compensation under this Division [Division 5 of Part 4 of the *Act* – Compensation in Relation to Death of a Worker], but not both a dependent spouse and one or more child dependants, and
>
> (b) leaves a dependent parent or dependent parents.
>
> (2) In addition to the compensation payable to the spouse or children, the Board must pay to the dependent parent or dependent parents an amount the Board considers is reasonable and proportionate to the pecuniary loss suffered by the dependent parent or dependent parents by reason of the worker's death.

(3) As a restriction on subsection (2), an amount paid under this section must not be greater than $795.05 per month for life or for a lesser period as determined by the Board.

Section 174:

(1) This section applies if a deceased worker does not leave a dependent spouse or a child dependant entitled to compensation under this Division [Division 5 of Part 4 of the *Act* – Compensation in Relation to Death of a Worker], but does leave other dependants.

(2) The Board must pay to the other dependants of the worker an amount the Board considers is reasonable and proportionate to the pecuniary loss suffered by those dependants by reason of the worker's death.

(3) As a restriction on subsection (2), the total of the amounts paid under this section must not be greater than $795.05 per month for life or for a lesser period as determined by the Board.

POLICY

1. Dependent Spouse and Children

If both a dependent spouse and children of the deceased worker are eligible for compensation as a result of the worker's death, no other person is entitled to compensation for the death, other than funeral and transportation expenses under Item C8-54.00.

2. Dependent Parents

If there is either a dependent spouse or one or more child dependants entitled to compensation as a result of a worker's death, but not both a spouse and one or more child dependants, compensation is payable for the dependent parent or dependent parents of the deceased worker.

The compensation payable to a dependent parent or dependent parents is in addition to the compensation payable to the dependent spouse or to the dependent child or children as a result of the worker's death.

A parent who was not wholly or partly dependent upon the worker's earnings at the time of the worker's death is not entitled to compensation under this Item. The parent may, however, be entitled to compensation under Item C8-56.70.

3. Other Dependants

If there is neither a dependent spouse nor a child dependant entitled to compensation as a result of a worker's death, compensation is payable to "other dependants" of the deceased worker.

The term "other dependants" means any of the following family members of the worker who were wholly or partly dependent on the worker's earnings at the time of the worker's death:

- parent(s) or step-parent(s);
- person who stood in place of a parent of the worker, whether or not the person is related to the worker;
- grandparent(s);
- child or children who do not meet the requirements under Item C8-53.10 to be eligible for compensation as a "child" of the deceased worker;
- grandchild(ren);
- stepchild or stepchildren who do not meet the requirements under Item C8-53.20 to be eligible for compensation as a "child" of the deceased worker;
- sibling(s) or half-sibling(s); and
- person to whom the worker stood in place of a parent, whether or not the person is related to the worker, and who does not meet the requirements under Item C8-53.20 to be eligible for compensation as a "child" of the deceased worker.

Except in the case of parents, a family member of the worker who is described in the above list and who was not wholly or partly dependent on the worker's earnings at the time of the worker's death is not entitled to compensation under the *Act*. A parent who was not wholly or partly dependent upon the worker's earnings may still be entitled to compensation under Item C8-56.70.

4. Calculation of Compensation

Compensation for a dependant under this Item is an amount the Board considers is reasonable and proportionate to the pecuniary loss suffered by the dependant as a result of the worker's death.

In determining the appropriate amount of compensation, the Board considers the amount of financial support that the dependant had been receiving from the worker at the date of the worker's death, or at the date of the injury resulting in death. The Board also considers the number of dependants eligible for compensation under this Item, as well as the maximum amount of compensation payable, as set out below.

The total amount of compensation payable for all dependants under this Item, taken together, must not be greater than the following amount:

January 1, 2025	—	December 31, 2025	$778.22
January 1, 2026	—	December 31, 2026	$795.05

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

5. Commencement of Compensation

Compensation under this Item commences on the day after the date of the worker's death.

6. Duration of Compensation

Compensation under this Item may be for life or for a lesser period as determined by the Board. For instance, the worker's grandchild might have been dependent upon the worker's earnings for payment of tuition fees. In such a case, the Board may determine that compensation should end when the grandchild ceases to attend school.

EFFECTIVE DATE: June 30, 2002
AUTHORITY: Sections 173 and 174 of the *Act*.
CROSS REFERENCES: Item C8-53.00, *Compensation on the Death of a Worker – Definitions – Meaning of "Dependant" and Presumptions of Dependency*;
Item C8-53.20, *Compensation on the Death of a Worker – Definitions – Meaning of "Child" or "Children"*;
Item C8-54.00, *Compensation on the Death of a Worker – Funeral and other Death Expenses*;
Item C8-56.70, *Compensation on the Death of a Worker – Calculation of Compensation – Persons with a Reasonable Expectation of Pecuniary Benefit*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:

April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
March 1, 2012 − Housekeeping changes made in accordance with legislative amendments to the then *Act*.
November 24, 2011 − Housekeeping amendments made in accordance with legislative amendments to the then *Act*.
June 30, 2002 − Replaced policy items #59.00 and #59.10 of the *Rehabilitation Services & Claims Manual,* Volume II.

APPLICATION:

This Item applies to the death of a worker on or after June 30, 2002.

RE:	Compensation on the Death of a Worker – Calculation of Compensation – Persons with a Reasonable Expectation of Pecuniary Benefit	ITEM:	C8-56.70

BACKGROUND

1. Explanatory Notes

This policy describes how compensation as a result of a worker's death is calculated for a person who, although not dependent on the worker's earnings at the time of the worker's death, had a reasonable expectation of pecuniary benefit from the worker.

2. The Act

Section 1, in part:

> **"dependant"** – See Item C8-53.00.

Section 175:

> (1) This section applies if
>
> (a) either
>
> (i) no compensation is payable under sections 169 to 174 in relation to a deceased worker, or
>
> (ii) the compensation is payable under those sections only to a spouse, a child or children or a parent or parents of the worker, and
>
> (b) the worker leaves a spouse, a child or children or a parent or parents who, although not dependent on the worker's earnings at the time of the worker's death, had a reasonable expectation of pecuniary benefit from the continuation of the life of the worker.
>
> (2) At the discretion of the Board, payments may be made to persons referred to in subsection (1)(b), but not to more than one of the categories of persons referred to in that provision.
>
> (3) As a restriction on subsection (2), the total of the amounts paid under this section must not be greater than $795.05 per month for life or for a lesser period determined by the Board.

POLICY

1. Persons with a Reasonable Expectation of Pecuniary Benefit

This Item applies if

(a) no compensation is payable to a dependant of the deceased, or

(b) the compensation is payable only to a spouse, a child or children, or a parent or parents,

but the worker leaves a spouse, child or children, or a parent or parents who, although not dependent on the worker's earnings at the time of the worker's death, had a reasonable expectation of pecuniary benefit from the continuation of the life of the worker.

A reasonable expectation of pecuniary benefit requires more than an assumption that the person would have received a financial benefit from the worker if the worker had not died. The evidence must support a finding that the worker would have provided an actual monetary benefit to the spouse, child or parent if the worker had not died.

Compensation may be payable to persons with a reasonable expectation of pecuniary benefit in only one of the following categories:

(a) spouse of the deceased worker;

(b) child or children of the deceased worker; or

(c) parent or parents of the deceased worker.

An application for compensation from a spouse, child or parent, on the grounds that they are a dependant of the deceased worker will automatically be considered under this Item if the Board concludes that the person was not wholly or partly dependent on the worker's earnings at the time of the worker's death.

2. Calculation of Compensation

Compensation under this Item is determined at the Board's discretion. However, monthly payments must not be greater than the following amount:

January 1, 2025	—	December 31, 2025	$778.22
January 1, 2026	—	December 31, 2026	$795.05

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

3. Commencement of Compensation

Compensation under this Item commences on the day after the date of the worker's death.

4. Duration of Compensation

Compensation under this Item may be for life or for a lesser period as determined by the Board. For instance, before death, the worker may have given a promissory note to a parent, undertaking to repay a loan with interest. In such a situation, the Board would not provide compensation for life because the parent's expectation of pecuniary benefit would not have been a lifelong expectation.

EFFECTIVE DATE:	February 1, 2020
AUTHORITY:	Section 175 of the *Act*.
CROSS REFERENCES:	Item C8-53.00, *Compensation on the Death of a Worker – Definitions – Meaning of "Dependant" and Presumptions of Dependency*; Item C8-53.20, *Compensation on the Death of a Worker – Definitions – Meaning of "Child" or "Children"*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	June 1, 2024 − Housekeeping changes made to modernize terminology by removing gendered language. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Policy amended to provide guidance on the legal issues of standard of proof and evidence. December 31, 2003 − Replaced policy item #60.00 of the *Rehabilitation Services & Claims Manual,* Volume II.
APPLICATION:	Applies to all decisions made on or after February 1, 2020, respecting the death of a worker on or after December 31, 2003.

RE:	Compensation on the Death of a Worker – Recalculation of Compensation on a Change in Circumstances	ITEM:	C8-57.00

BACKGROUND

1. Explanatory Notes

This policy describes the recalculation of compensation when there has been a change in a dependant's circumstances.

2. The Act

Section 181:

(1) This section applies if

(a) a deceased worker has left both a dependent spouse and child dependants, and

(b) subsequently there is a reduction in the number of child dependants.

(2) The dependent spouse and remaining child dependants are then entitled to the compensation that would have been payable if the worker's death had occurred on the date the number of child dependants was reduced.

Section 182:

(1) This section applies if

(a) a deceased worker has left both a dependent spouse and dependent children, and

(b) the dependent spouse subsequently ceases to have dependent children.

(2) The dependent spouse is entitled to the compensation that would have been payable if the worker's death had occurred on the date the dependent spouse ceased to have dependent children.

Section 183:

(1) This section applies if

(a) a deceased worker leaves a dependent spouse and one or more dependent children, and

(b) the dependent spouse subsequently dies.

(2) Compensation to the dependent children must continue and be calculated in the same manner as if the worker had died leaving no dependent spouse.

Section 184:

(1) This section applies if

(a) a deceased worker leaves dependent children and no dependent spouse, and

(b) subsequently there is a reduction in the number of dependent children.

(2) The remaining dependent children are entitled to the compensation that would have been payable if the worker's death had occurred on the date the number of dependent children was reduced.

Section 185:

(1) This section applies if

(a) a deceased worker leaves a dependent spouse who has had a physical or mental disability that resulted in the spouse being incapable of earning, and

(b) the dependent spouse subsequently ceases to have that disability.

(2) The dependent spouse is entitled to the compensation that would have been payable if the worker's death had occurred on the date the dependent spouse ceased to have the disability.

Section 228:

(1) In this section:

"former Act" means the *Workers Compensation Act*, R.S.B.C. 1996, c.492;

"transition date" means December 31, 2003, being the date on which this section came into force.

(2) This section applies to a worker's death that occurred before June 30, 2002.

(3) Subject to subsections (5) and (6), the former Act, as it read immediately before June 30, 2002, applies to a death referred to in subsection (2).

(4) Subject to subsections (5) and (6), in recalculating compensation under sections 181 to 185 *[compensation adjustment when there are changes in circumstances]* of this Act, the Board must, if the actual date of the worker's death was before June 30, 2002, base the recalculation on the former Act as it read immediately before June 30, 2002.

(5) Section 334 *[annual adjustment of periodic payment amounts]* applies to compensation paid on or after the transition date in respect of a worker's death, irrespective of the date the worker died.

(6) For the purposes of applying subsections (3) and (4), the Board must adjust the dollar amounts referred to in sections 17 *[compensation in fatal cases]* and 18 *[addition to payments in relation to worker death before July 1, 1974]* and Schedule C *[Payments to Widows]* of the former Act, as it read immediately before June 30, 2002, in accordance with section 333(1) *[annual adjustment of dollar amounts referred to in Act]* of this Act.

POLICY

1. Recalculation of Compensation on a Change in Circumstances

Compensation payable as a result of the death of a worker is recalculated when there has been a change in circumstances as follows:

(a) there is a dependent spouse and child dependants, and the change in circumstance is a reduction in the number of child dependants;

(b) a dependent spouse with dependent children ceases to have dependent children;

(c) there is a dependent spouse and one or more dependent children, and the dependent spouse subsequently dies;

(d) there is no dependent spouse, but there are dependent children, and there is a reduction in the number of dependent children; or

(e) a dependent spouse who has had a physical or mental disability that resulted in the spouse being incapable of earning ceases to have that disability.

When a change in circumstances occurs, as described in (a) to (e) above, the Board recalculates compensation as if the worker died on the date that the change occurred, subject to the exception discussed in Section 2 of this Item.

For instance, in the circumstances described in (c) above, where a worker is survived by a dependent spouse and one or more dependent children, and the dependent spouse subsequently dies, compensation is recalculated as if the worker died leaving no dependent spouse. In such a situation, compensation for the one or more dependent children would be determined under Item C8-56.40.

When recalculating compensation on a change in circumstances, it is necessary to determine the amount that would have been payable to the deceased worker for a permanent total disability. That amount is calculated by reference to the date of injury or the date of disablement from occupational disease and not by reference to the date of death (unless it is the same) or to the date of the change of circumstances. However, cost of living adjustments to the resulting figure will be made up to the date of the change in circumstances.

The recalculated level of compensation applies as of the date of the change in circumstances. For instance, where the change that leads to the recalculation is a change in a child's school attendance or a child's birthday, the Board uses the exact date when the change occurs as the date of commencement of the new compensation payments. For example, where a child who is no longer attending school turns 19 on December 15, the old compensation payment would remain in effect until December 14 and the new payment amount would become effective on December 15.

Dependants are advised at the outset of the claim of the various provisions that may result in a change in compensation payable to them. They are also advised in advance of a potential change in their payment amount resulting from an age change in a dependent child.

2. Exception – Deaths before June 30, 2002

If the actual date of the worker's death was before June 30, 2002, the recalculation of compensation is based on the *Workers Compensation Act*, R.S.B.C. 1996, c. 492 as it read immediately before June 30, 2002.

The policies in Volume I of this *Manual* apply in such cases. However, cost of living adjustments to benefits paid on or after December 31, 2003 are made in accordance with Item C7-51.00 of Volume II of this *Manual*. In addition, the dollar amounts referred to in sections 17 and 18 and Schedule C of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492 as it read immediately before June 30, 2002, are adjusted in accordance with Item C7-51.00 of Volume II of this *Manual*.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	Sections 181, 182, 183, 184, 185, and 228 of the *Act*.
CROSS REFERENCES:	Item C7-51.00, *Cost of Living Adjustments to Periodic Payments*; Item C8-53.00, *Compensation on the Death of a Worker – Definitions – Meaning of "Dependant" and Presumptions of Dependency*; Item C8-53.20, C*ompensation on the Death of a Worker – Definitions – Meaning of "Child" or "Children"*; Item C8-56.00, *Compensation on the Death of a Worker – Calculation of Compensation – Dependent Spouse with Children*; Item C8-56.10, *Compensation on the Death of a Worker – Calculation of Compensation – Dependent Spouse with No Children*; Item C8-56.40, *Compensation on the Death of a Worker – Calculation of Compensation – Children*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – Housekeeping change to update internal cross-references, consequential to reformatting and renumbering Chapter 7, *Protection of and Deductions from Benefits*. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. November 24, 2011 − Housekeeping amendments made in accordance with legislative amendments to the then *Act.* June 30, 2002 − Replaced policy item #55.50 of the *Rehabilitation Services & Claims Manual,* Volume II.
APPLICATION:	This Item applies to the death of a worker on or after June 30, 2002.

RE:	Compensation on the Death of a Worker – Apportionment of Compensation	ITEM:	C8-58.00

BACKGROUND

1. Explanatory Notes

This policy describes how the Board apportions compensation among dependants in situations where there is a need to do so.

2. The Act

Section 177:

(1) Subject to subsection (2), if it is necessary to apportion compensation payable to dependants among those dependants, the formula for apportionment is at the discretion of the Board.

(2) Unless the Board has grounds for a different apportionment, apportionment of the following must be in accordance with this subsection:

(a) if there is a dependent spouse and one child dependant, 2/3 of the compensation is payable to the spouse and 1/3 to the child;

(b) if there is a dependent spouse and more than one child dependant, 1/2 of the compensation is payable to the spouse and 1/2 among the children in equal shares;

(c) if there is more than one child dependant but no dependent spouse, the compensation is payable to the children in equal shares.

POLICY

If it is necessary to apportion compensation payable to dependants among those dependants, the Board has discretion in determining the formula for apportionment. However, unless the Board has grounds for a different apportionment, the following apportionment applies:

(a) if there is a dependent spouse and one child dependant, 2/3 of the compensation is payable to the spouse and 1/3 to the child;

(b) if there is a dependent spouse and more than one child dependant, 1/2 of the compensation is payable to the spouse and 1/2 among the children in equal shares;

(c) if there is more than one child dependant but no dependent spouse, the compensation is payable to the children in equal shares.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Section 177 of the *Act*.
CROSS REFERENCES:	Item C8-53.00, *Compensation on the Death of a Worker – Definitions – Meaning of "Dependant" and Presumptions of Dependency*; Item C8-53.20, *Compensation on the Death of a Worker – Definitions – Meaning of "Child" or "Children"*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. December 31, 2003 − Replaced policy items #61.00 and #61.10 of the *Rehabilitation Services & Claims Manual,* Volume II.
APPLICATION:	This Item applies to the death of a worker on or after December 31, 2003.

RE:	Compensation on the Death of a Worker − Death of More than One Worker	ITEM:	C8-59.00

BACKGROUND

1. Explanatory Notes

This policy describes how compensation is calculated for a dependant of more than one deceased worker.

2. The Act

Section 186:

(1) Subject to subsection (2), if a dependant is entitled to receive compensation under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants].

(a) as a result of the worker's death, and

(b) as a result of the subsequent death of another worker,

the total compensation payable for the dependant as a result of those deaths is an amount that the Board considers appropriate.

(2) The compensation payable for a dependant under subsection (1)

(a) must not be less than the greatest of the amounts that would otherwise be payable in respect of the death of any of the workers, and

(b) must not be greater than 90% of the average net earnings of a worker whose wage rate is the maximum wage rate established under section 209 *[maximum wage rate for average earnings]* for the year in which the last death referred to in subsection 1(b) occurred.

(3) For the purposes of subsection (2), the average net earnings for the worker are to be calculated in accordance with section 220 *[determination of average net earnings: short-term compensation]*.

POLICY

Death of More than One Worker

If a dependant, who is entitled to compensation as a result of a worker's death, becomes eligible for compensation as a result of another worker's death, the total compensation payable as a result of the deaths is an amount the Board considers appropriate.

Total compensation under this Item must not be less than the greatest of the amounts payable as a result of the death of any of the workers.

The maximum compensation payable is calculated as follows:

(a) The maximum wage rate for the year in which the last worker died is used as average earnings to calculate average net earnings.

(b) Short-term average net earnings are calculated in accordance with Item C9-71.00.

(c) Compensation payable is based on 90% of the short-term average net earnings.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	Section 186 of the *Act*.
CROSS REFERENCES:	Item C9-71.00, *Average Net Earnings*, of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	July 4, 2025 – Housekeeping changes related to the reformatting and renumbering of Chapter 9, *Average Earnings*, of the *Rehabilitation Services & Claims Manual, Volume II*. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 30, 2002 − Replaced policy item #61.30 of the *Rehabilitation Services & Claims Manual,* Volume II.
APPLICATION:	This Item applies to the death of a worker on or after June 30, 2002.

RE:	Compensation on the Death of a Worker – Enemy Warlike Action	ITEM:	C8-60.00

BACKGROUND

1. Explanatory Notes

This policy describes how compensation is calculated for a worker who is injured or killed in the course of the worker's employment as a direct result of enemy warlike action or counteraction.

2. The Act

Section 234:

(1) This section applies if

(a) a worker's personal injury, disablement or death occurs in the course of the worker's employment as a direct result of enemy warlike action or counteraction taken against such enemy action,

(b) provision has been made by the government of Canada for compensation for the worker or the worker's dependants in respect of the injury, disablement or death.

(2) The worker or the worker's dependants are entitled to compensation under this Part only if the compensation provided by the government of Canada is less than that provided by this Act, and then only to the extent of the difference.

POLICY

Enemy Warlike Action

This policy applies if:

(a) a worker's personal injury, disablement or death occurs in the course of the worker's employment as a direct result of enemy warlike action or counteraction; and

(b) the government of Canada has provided for compensation for the worker or the worker's dependants as a result of the personal injury, disablement or death.

In the circumstances described above, if the government of Canada provides for less compensation than that provided by the *Act*, compensation is payable to the worker or the worker's dependants in an amount equal to the difference. If the compensation provided by the government of Canada is equal to or greater than that provided under the *Act*, no compensation is payable by this *Act*.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Section 234 of the *Act*.
CROSS REFERENCES:	Item C8-53.00, *Compensation on the Death of a Worker – Definitions – Meaning of "Dependant" and Presumptions of Dependency*, of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. December 31, 2003 − Replaced policy item #61.20 of the *Rehabilitation Services & Claims Manual,* Volume II.
APPLICATION:	This Item applies to a death or injury on or after December 31, 2003.

RE: Compensation on the Death of a Worker − Special or Novel Cases **ITEM: C8-61.00**

BACKGROUND

1. Explanatory Notes

This policy describes how the Board has discretion, in certain situations, to deviate from the strict application of the survivor benefit provisions in the *Act*.

2. The Act

Section 189:

> If
>
> (a) a situation arises that is not expressly covered by this Division [Division 5 of Part 4 of the *Act* – Compensation in Relation to Death of a Worker], or
>
> (b) some special additional facts are present that the Board considers would make the strict application of this Division inappropriate,
>
> the Board must make rules and make decisions the Board considers fair, using this Division as a guideline.

POLICY

Special or Novel Cases

If a situation arises that is not expressly covered by the policies discussed in this chapter or if some special additional facts are present that the Board considers would make the strict application of those policies inappropriate, the Board makes rules and makes decisions the Board considers fair, using those policies as a guideline.

EFFECTIVE DATE: December 31, 2003
AUTHORITY: Section 189 of the *Act*.
CROSS REFERENCES:
HISTORY: April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

APPLICATION:

December 31, 2003 − Replaced policy item #61.40 of the *Rehabilitation Services & Claims Manual,* Volume II. This Item applies to the death of a worker on or after December 31, 2003.

RE: Compensation on the Death of a Worker – Proof of Existence of Dependants **ITEM: C8-62.00**

BACKGROUND

1. Explanatory Notes

This policy addresses the proof required by the Board to confirm the existence and condition of a deceased worker's dependants.

2. The Act

Section 188:

(1) The Board may from time to time require the proof the Board considers necessary of the existence and condition of dependants receiving compensation payments under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants].

(2) If the Board requires proof under this section, the Board may withhold further compensation payments until that proof is received.

POLICY

Proof of Existence of Dependants

The application for compensation submitted by a dependant should be accompanied by marriage and/or birth certificates or other evidence establishing the applicant's relationship to the deceased worker.

Each year, the Board mails out, to dependants receiving compensation under Division 5 of Part 4 of the *Act* [Compensation in Relation to Death of Worker], declaration forms and school attendance forms. Failure to complete and return these forms may result in payments being withheld until those forms are received by the Board.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Section 188 of the *Act*.
CROSS REFERENCES:	Item C8-53.00, *Compensation on the Death of a Worker – Definitions – Meaning of "Dependant" and Presumptions of Dependency*, of the *Rehabilitation Services & Claims Manual,* Volume II.

HISTORY: April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
December 31, 2003 − Replaced policy item #61.50 of the *Rehabilitation Services & Claims Manual,* Volume II.

APPLICATION: This Item applies to the death of a worker on or after December 31, 2003.

RE:	Compensation on the Death of a Worker – Death of a Commercial Fisher	ITEM:	C8-63.00

BACKGROUND

1. Explanatory Notes

This policy describes entitlement to compensation following the death of a commercial fisher.

2. The Act

Section 8(3):

> If the death of a commercial fisher resident in British Columbia
>
> (a) arises out of and in the course of the commercial fisher's occupation in British Columbia or waters off British Columbia, and
>
> (b) is not otherwise compensable under the compensation provisions [of the *Act*],
>
> the Board may treat the death in the same manner as if the commercial fisher were a worker employed by the Crown in right of British Columbia.

POLICY

Death of a Commercial Fisher

If the death of a commercial fisher resident in British Columbia arises out of and in the course of the commercial fisher's occupation in British Columbia or waters off British Columbia, and is not otherwise compensable, the Board may treat the death in the same manner as if the commercial fisher were a worker employed by the Crown in right of British Columbia.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Section 8 of the *Act*.
CROSS REFERENCES:	
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. December 31, 2003 − Replaced policy item #61.70 of the *Rehabilitation Services & Claims Manual*, Volume II.
APPLICATION:	This Item applies to the death of a worker on or after December 31, 2003.

RE: Average Earnings – Introduction **ITEM: C9-64.00**

BACKGROUND

1. Explanatory Notes

This policy provides an introduction on how the Board determines average earnings.

2. The Act

Section 208, in part:

> (1) The Board must determine the amount of a worker's average earnings and the worker's earning capacity with reference to the worker's average earnings and earning capacity at the time of the worker's injury.
>
> (2) The Board must determine the amount of a worker's average earnings in accordance with this Division [Division 7 of Part 4 of the *Act* — Worker's Average Earnings and Earning Capacity], subject to the restriction that the amount may not exceed the maximum wage rate as determined under section 209 [Annual determination of maximum wage rate for average earnings].
>
> …

POLICY

Section 208 provides the general direction for determining a worker's average earnings.

The *Act* provides two general rules for determining average earnings and a number of exceptions for which average earnings are calculated differently. The exceptions relate to a casual worker, a person who purchased coverage under section 4(2) of the *Act*, a worker with no earnings on the date of injury, a worker in a public interest undertaking, a worker who is an apprentice or learner, a regular worker who has been employed less than 12 months, and a worker with exceptional circumstances.

In determining a worker's average earnings, the Board must apply one of the general rules unless one of the exceptions in the *Act* applies to a worker. If more than one exception applies to the same worker for the same injury, the *Act* provides that the Board must determine the section that best reflects the worker's circumstances and

apply that section. In making this determination, "best" does not mean the highest rate possible, but rather, the rate that most closely reflects the actual loss incurred.

Set out in this chapter are the Board's policies with respect to the calculation of a worker's short-term average earnings; the application of a 10-week average earnings rate review; the calculation of a worker's long-term average earnings; and the composition of average earnings.

EFFECTIVE DATE:	July 4, 2025
AUTHORITY:	Sections 208 and 219 of the *Act*.
CROSS REFERENCES:	Item C9-65.00, *General Rule for Determining Short-Term Average Earnings*; Item C9-66.00, *General Rule for Determining Long-Term Average Earnings*; Item C9-67.00, *Exceptions to General Rules – Short-Term and Long-Term Average Earnings*; and Item C9-67.10, *Exceptions to General Rule – Long-Term Average Earnings*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	July 4, 2025 – Former policy item #64.00, of the *Rehabilitation Services Claims Manual,* Volume II, reformatted consequential to reformatting and renumbering the policies in Chapter 9. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
APPLICATION:	Applies to all decisions made on or after July 4, 2025.

RE:	General Rule for Determining Short-Term Average Earnings	ITEM:	C9-65.00

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the general rule for determining short-term average earnings for workers.

2. The Act

Section 210:

(1) Subject to this Division [Division 7 of Part 4 of the *Act* — Worker's Average Earnings and Earning Capacity], the Board must determine, for the shorter of the following periods, the amount of a worker's average earnings based on the rate at which the worker was remunerated by each of the employers for whom that worker was employed at the time of the injury:

(a) the initial payment period, being the period

(i) starting on the date of the injury, and

(ii) ending on the last day of the tenth week for which compensation is payable under this Part [Part 4 of the *Act* — Compensation to Injured Workers and Their Dependants] to the worker for a temporary disability resulting from that injury;

(b) the period starting on the date of the worker's injury and ending on the date the worker's injury results in a permanent disability, as determined by the Board.

POLICY

A. INTRODUCTION

Except for a casual worker, a person who purchased coverage under section 4(2) of the *Act*, a worker with no earnings at the time of the injury, and a worker in a public interest undertaking, the general rule for determining short-term average earnings is to use the worker's rate of pay at the time of injury up to the maximum wage rate permitted by the *Act.*

For workers who receive regular remuneration on a repeating pattern, for example over a five-day work week, the determination of the worker's earnings at the time of the injury will be based on the worker's rate of pay on the date of injury.

B. VARIABLE EARNINGS

The Board recognizes that not all workers receive regular remuneration based on a repeating pattern. Accordingly, calculating time of the injury earnings based on a worker's rate of pay on the date of the injury is not always appropriate. The guidelines set out below apply in determining short-term average earnings where a worker is regularly employed with variable earnings.

The Board considers a worker to have variable earnings if the worker:

- works on call for one or more employers at differing rates of pay and does not have a casual pattern of employment;
- has irregular shifts;
- has shifts with no repeating patterns;
- works a shift cycle involving more than five cycles;
- works differing shift hours per cycle;
- is paid shift differentials; or
- is scheduled for a shift cycle change.

For such workers with variable earnings, the Board will usually calculate the short-term average earnings with reference to the worker's earnings in the three-month period up to and including the worker's date of injury. The Board may however use a shorter or longer time period if it determines this is a more accurate reflection of the worker's time of the injury earnings.

Situations where a shorter or longer time period may be used include:

- if a regularly employed worker with variable earnings has been with an employer for less than three months, the worker's short-term average earnings are based on the worker's earnings from the worker's date of hire up to and including the date of the injury.
- if the worker received wage-loss benefits (or wage-loss equivalent vocational rehabilitation allowances/benefits) during the three-month period prior to the date of injury.

- if the worker has experienced a significant atypical and/or irregular disruption in the pattern of employment during the three-month period prior to the date of the injury. This circumstance may arise, for example, if the worker had a lengthy absence due to a non-compensable illness or injury, educational or maternity/paternity reasons.

In such situations, the Board may choose to exclude a portion of the time period over which earnings are averaged if doing so would provide a more accurate reflection of the worker's time of the injury earnings. The Board does not generally exclude short absences from work for non-compensable reasons or minor fluctuations in hours worked or rate of pay.

In cases where a worker is regularly employed but has variable earnings due to differing shift hours per cycle, the time period for determining average daily earnings may be adjusted if the worker misses a shift or shifts during which their earnings significantly deviate from the daily earnings of that particular shift cycle.

C. WORKER WITH MULTIPLE EMPLOYMENTS

If a worker is engaged in multiple employments and is disabled by an injury arising out of and in the course of one of them, the worker's earnings at the time of the injury will be based on the combined earnings of all employments up to the statutory maximum. This applies whether or not the other employments are covered by the compensation provisions of the *Act* or are self-employment. The total days worked in all employments are merged to obtain the days worked per week. Employers, if covered by the compensation provisions of the *Act*, may be reimbursed by the Board if they continue paying the disabled worker (Section 3 of the policy in Item C5-34.10).

If a worker is engaged in multiple employments and has purchased Personal Coverage for at least one of them, the income earned in the non-Personal Coverage employments will be combined with the amount of Personal Coverage purchased for the other employments in order to determine average earnings, subject to the statutory maximum.

D. FISHERS

The worker's earnings at the time of the injury for fishers whose remuneration is based on a share of the catch, the value of which may only be determined at a future date, will be based on the earnings over the three-month period immediately preceding the date of the injury. If earnings information is not available for that three-month period, the worker's average earnings may be based on the 12-month period immediately preceding the worker's date of injury. See also Item C9-68.10 for information on a fisher's composition of average earnings if the fisher deducts equipment and/or operating expenses from gross income for business or taxation purposes and owns a vessel or other equipment used to harvest fish.

E. TEACHERS

In most cases, short-term average earnings for workers employed as teachers are determined using the general rule. Permanent, full-time teachers are often paid an annual salary and may choose to have it paid over the course of a 10- or 12-month time period. Regardless of which time period the salary is paid over, the Board will determine the worker's short-term average earnings using the amount of the annual salary, unless an exception to the general rule applies.

If a permanent, full-time teacher earning an annual salary is engaged in multiple employments and is disabled from an injury arising in and out of the course of one of them, short-term average earnings will be determined as set out in Section C of this policy. The Board will use the amount of the annual salary for the purposes of this determination.

F. WORKERS PARTICIPATING IN NON-BOARD SPONSORED RETURN TO WORK PROGRAMS

If a worker is participating in a non-Board sponsored Return to Work program, insurance proceeds may be considered earnings for the purposes of determining short-term average earnings. Generally, for insurance proceeds to be considered earnings, payment must relate to the work being performed.

For example, if a worker is only in the workplace for four hours, but receives a top up in insurance proceeds for an additional four hours not related to the work being performed, the insurance proceeds are not considered to be earnings for the purposes of determining short-term average earnings. Conversely, if the worker is in the workplace for eight hours, and the worker receives half of the worker's wages through payment of insurance proceeds, the insurance proceeds may be considered earnings for the purposes of determining short-term average earnings.

Evidence which demonstrates that payment of insurance proceeds relate to the work being performed includes, but is not limited to:

- Continued payment of insurance proceeds is dependent upon active participation in the Return to Work program.
- The employer funds the insurance program as a wage replacement scheme.
- The Return to Work program is integrated into the normal production activities of the host employer.

See Item C9-67.10 to determine the long-term average earnings for a worker participating in a non-Board sponsored Return to Work program.

EFFECTIVE DATE:	July 4, 2025
AUTHORITY:	Section 210 of the *Act*.
CROSS REFERENCES:	Item C5-34.10, *Payment of Wage-Loss Benefits*; Item C9-65.10, *Provisional Rate*; Item C9-66.00, *General Rule for Determining Long-Term Average Earnings*; Item C9-67.00, *Exceptions to General Rules – Short-Term and Long-Term Average Earnings*; and Item C9-67.10, *Exceptions to General Rule – Long-Term Average Earnings*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	March 2, 2026 – Housekeeping change to update the term "Personal Optional Protection" to "Personal Coverage." July 4, 2025 – This policy consolidates former policy items #65.00, #65.01, #65.02, #65.03, #65.05, of the *Rehabilitation Services & Claims Manual,* Volume II, and adds guidance for workers with variable earnings, workers with multiple employments, and teachers, consequential to reformatting and renumbering the policies in Chapter 9. January 1, 2024 − Housekeeping change to update internal cross reference. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
APPLICATION:	Applies to all decisions made on or after July 4, 2025.

RE: Provisional Rate **ITEM: C9-65.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on when compensation is based on a provisional rate.

2. The Act

Section 210:

See Item C9-65.00.

Section 211:

> Subject to this Division [Division 7 of Part 4 of the *Act* — Worker's Average Earnings and Earning Capacity], if a worker's disability continues after the end of the shorter period referred to in section 210 [Average earnings: short-term compensation], the Board must, for the period starting after the end of that period, determine the amount of the worker's average earnings based on the worker's gross earnings, as determined by the Board, for the 12-month period immediately preceding the date of the worker's injury.

POLICY

Compensation may be based on a provisional rate when the following conditions are present:

i. there is some significant delay in obtaining information necessary to determine the worker’s short-term or long-term average earnings;

ii. the Board is unable to avoid that delay; and

iii. the worker is not causing the delay.

The worker is informed that a provisional rate has been set.

The amount of the provisional rate depends on the information available to the Board. While being careful not to set a rate which is higher than the worker’s actual earnings, the Board should, as far as is possible, take into consideration the actual circumstances of the worker, for instance, age, occupation, seniority and union status. The Board

should also have regard to statements of earnings already on file or on other recent compensation claims.

If the Board sets a provisional rate, this is a preliminary determination pending receipt of further information required to determine a worker's average earnings. If sufficient earnings information is received after payments have been made based on a provisional rate, a decision on the worker's average earnings will then be made.

A preliminary determination to set a provisional rate is not a "decision" for the purposes of section 123 of the *Act*. Rather, it is a Board action that is intended to provide temporary financial relief to the worker until the Board receives the required information to make a decision on the worker's average earnings. However, once the Board makes the average earnings decision, that decision is subject to the provisions of section 123(2).

If insufficient earnings information or no information is received after a reasonable time, the Board will review the rate at least every four weeks from the date of the preliminary determination until the decision on average earnings is made. In setting a provisional rate, the Board considers the applicable statutory minimum (Section 2 of the policy in Item C5-33.10). See Item C12-93.20 regarding a worker's obligation to provide information. Where payments based on a provisional rate have been commenced, and the average earnings decision sets a rate lower than the provisional rate previously set, no recovery of the payments will be made in the absence of an administrative error, fraud or misrepresentation by the worker. For a definition of an administrative error, refer to Item C7-48.10.

EFFECTIVE DATE:	July 4, 2025
AUTHORITY:	Section 210 and 211 of the *Act*.
CROSS REFERENCES:	Item C7-48.10, *Overpayments/Money Owed to the Board*; Item C9-65.00, *General Rule for Determining Short-Term Average Earnings*; Item C9-66.00, *General Rule for Determining Long-Term Average Earnings*; Item C12-93.20, *Obligation to Provide Information*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 − Housekeeping change to update internal cross-references, consequential to reformatting and renumbering Chapter 7, *Protection of and Deductions from Benefits* and Chapter 12, *Claims Procedures*. July 4, 2025 − Former policy item #65.04 of the *Rehabilitation Services & Claims Manual*, Volume II reformatted consequential to reformatting and renumbering policies in Chapter 9. January 1, 2024 − Housekeeping change to update internal cross reference. October 29, 2020 – Amended to reflect amendment to the reconsideration provisions of the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020.

April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
May 1, 2010 – Amended to clarify when a provisional rate may be used and to change references to average net earnings to average earnings.
June 1, 2009 – Deleted references to Board officers.
March 3, 2003 – Amended to provide that where the Board sets a provisional rate, this is a preliminary determination pending receipt of further information. Policy also provides that a preliminary determination is not a decision for the purposes of the time limits for reconsideration.

APPLICATION: Applies to all decisions made on or after July 4, 2025.

RE:	General Rule for Determining Long-Term Average Earnings	ITEM:	C9-66.00

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the general rule for determining long-term average earnings for workers.

2. The Act

Section 211:

> Subject to this Division [Division 7 of Part 4 of the *Act* — Worker's Average Earnings and Earning Capacity], if a worker's disability continues after the end of the shorter period referred to in section 210 [Average earnings: short-term compensation], the Board must, for the period starting after the end of that period, determine the amount of the worker's average earnings based on the worker's gross earnings, as determined by the Board, for the 12-month period immediately preceding the date of the worker's injury.

POLICY

After a claim has lasted five weeks, the Board considers whether it is likely to last for ten weeks and, if the Board has not done so already, sets in motion any enquiries necessary for a possible 10-week average earnings review.

As part of the Board's enquiries, information will be obtained as to the worker's earnings for the 12-month period immediately preceding the date of the worker's injury. Information will also be obtained about the worker's tax status for the previous year.

If not supplied by the employer, earnings and tax status information for the required period of time prior to the injury must be provided by the worker. The information provided must be verified information from an independent source such as wage stubs, T4s, or letters from the Income Tax Authorities or employers.

If, at the earlier of: the day after 10 cumulative weeks of wage-loss benefits have been paid to the worker; or the effective date of the worker's permanent disability benefits, there is insufficient information on which to complete the 10-week rate review, a provisional rate may be set until sufficient information is received (see Item C9-65.10).

In situations where a worker is being maintained on full salary by the employer, the Board will still be required to carry out a rate review of this kind and, if a reduction is warranted, to make the necessary adjustment. If the worker's long-term earnings average out in excess of the rate set at the time of the injury and the figure being paid by the employer, it is conceivable that the worker could be in a less advantageous position than other workers with a similar earnings pattern. As such, a rate increase can be initiated and the difference between the new rate and what is being refunded to the employer made payable to the worker. This would not apply if the employer is paying the worker at the maximum applicable to the claim. If an employer ceases to make payments to a worker, the Board will begin to pay the worker directly.

EFFECTIVE DATE:	July 4, 2025
AUTHORITY:	Section 211 of the *Act*.
CROSS REFERENCES:	Item C4-26.00, *"Date of Injury" For Occupational Disease*; Item C5-34.10, *Payment of Wage-Loss Benefits*; Item C9-65.00, *General Rule for Determining Short-Term Average Earnings*; and Item C9-65.10, *Provisional Rate*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	July 4, 2025 – Former policy #66.00 of the *Rehabilitation Services & Claims Manual*, Volume II reformatted consequential to reformatting and renumbering policies in Chapter 9. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. November 25, 2015 – By Board of Directors Resolution No. 2015/11/25-02, the application statement of this policy was revised on November 25, 2015.
APPLICATION:	Applies to all decisions made on or after July 4, 2025.

RE: Exceptions to General Rules – Short-Term and Long-Term Average Earnings **ITEM: C9-67.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the statutory exceptions to both general rules for determining short-term and long-term average earnings: a casual worker, a person who has purchased Personal Coverage, a worker with no earnings, and a worker in a public interest undertaking.

2. The Act

Section 212:

> If a worker had no earnings at the time of the injury, the Board must determine the amount of a worker's average earnings from the date of injury in a manner that the Board considers appropriate.

Section 213:

> (1) This section applies to a person who is
>
> (a) deemed to be a worker under section 5 *[extending application: public interest undertakings]*, and
>
> (b) not regularly employed.
>
> (2) The Board may, on the terms and conditions the Board directs, fix the amount of a person's average earnings having regard to all the circumstances, including the person's income.
>
> (3) As a restriction, an amount fixed under subsection (2) must not be less than $170.86 per week.

Section 214:

> If a worker's pattern of employment at the time of the injury is casual in nature, the Board's determination of the amount of the worker's average earnings from the date of injury must be based on the worker's gross earnings, as determined by the Board, for the 12-month period immediately preceding the date of injury.

Section 215:

> If an employer or independent operator to whom the Board directs that the compensation provisions apply under section 4 (2) *[coverage for independent operators and employers]* has purchased coverage under this Act, the Board must determine the amount of the employer's or independent operator's average earnings from the date of injury based on the gross earnings for which coverage is purchased.

Section 219:

> If 2 or more of sections 212 [Worker without earnings: short-term and long-term compensation] to 218 [Exceptional circumstances: long-term compensation] apply to the same worker for the same injury, the Board must determine the section that best reflects the worker's circumstances and apply that section.

POLICY

A. INTRODUCTION

The *Act* provides a number of exceptions to the general rules in setting a worker's short-term and long-term average earnings. The Board's policies with respect to each of these exceptions are presented below. If a worker's circumstances do not fit within any of the exceptions, the applicable general rule for determining a worker's average earnings applies.

Section 219 of the *Act* provides that if two or more exceptions to the general rules for determining average earnings apply to the same worker for the same injury, the Board must determine and apply the section that best reflects the worker's circumstances. In making this determination, "best" does not mean the highest rate possible, but rather, the rate that most closely reflects the actual loss incurred. This situation could arise if, for example, a worker was an apprentice (section 216) who had been employed less than 12 months (section 217). In this situation, the Board would apply the section that most accurately reflects the worker's average earnings and earning capacity at the time of injury.

B. CASUAL PATTERN OF EMPLOYMENT

Section 214 is an exception to both general rules for determining a worker's average earnings. The Board must use the worker's gross earnings for the 12-month period immediately before the date of injury to establish the worker's average earnings. There is no 10-week average earnings review. Thus, the worker's average earnings determined at the outset of the casual worker's claim are also the worker's long-term average earnings.

This provision is applied in those situations where, due to the unpredictable, sporadic and/or transitory pattern of the worker's employment, the initial rate general rule would not provide an appropriate representation of a worker's loss of earnings. In these situations, it is considered that earnings over the 12-month period immediately before the date of injury more appropriately reflect the worker's loss of earnings.

Determination of whether a worker's pattern of employment is casual in nature involves a two-step investigation.

1. The first step involves a consideration of the nature of the worker's job at the time of the injury. This will identify:

   (a) those workers to whom the general rules of sections 210, 211 and 219 should apply;

   (b) those workers who have purchased coverage under section 4(2) of the *Act*, to whom the section 215 exception applies;

   (c) those workers who were an apprentice or learner, to whom the section 216 exception applies; and

   (d) those workers who were employed, on other than a casual or temporary basis, by the worker's employers for less than 12 months immediately preceding the date of the injury, to whom the section 217 exception applies.

   Certain workers will not clearly fall within the above categories. An indicator that a worker may fall within the section 214 exception is that the worker's job at the time of injury was not permanent and/or was scheduled to last less than three months. However, this is not conclusive of the issue and the second step of the investigation must then be undertaken.

2. If a worker does not clearly fall within the above categories, the second step involves consideration of the worker's pattern of employment over a longer period of time. In order to determine whether the worker's pattern of employment is casual, it may be necessary to consider the worker's employment activities in the period prior to the injury.

   A casual pattern of employment may be demonstrated if the worker has a history of short-term jobs and significant absences from employment between jobs. A worker's pattern of employment will generally be considered casual if, although periodically engaged in employment activities, the worker's employment cannot demonstrate a consistent attachment to the workforce.

Where the worker's employment represents their initial entry into the workforce, the absence of any other employment activity in the period prior to the injury is not conclusive of a pattern of casual employment.

An employer's reference to a worker as a "casual worker" is not conclusive of the worker's categorization.

After the Board has considered the worker's attachment to employment, the evidence is weighed to determine whether the worker's pattern of employment at the time of the injury was casual in nature.

C. PERSONAL COVERAGE

Section 215 is an exception to both general rules for determining average earnings. The average earnings of a person entitled to Personal Coverage under section 4(2) of the *Act* are the earnings for which coverage has been purchased. There is no 10-week average earnings review.

If a claim is made in respect of an injury, a disablement from an occupational disease, or a death from either cause occurring on or after January 1, 1978, the minimum amounts of compensation provided for in sections 191(2), 192(2), 194(2) and 195(2) have no application to persons who have purchased Personal Coverage (Item AP1-4-3 of the *Assessment Manual*). However, the minimum average earnings provided for in sections 171(4) and 172(5) do apply.

The amount of Personal Coverage purchased will be used to calculate a person's average net earnings. Compensation will be based on 90% of the person's average net earnings calculated as set out in Item C9-71.00.

Compensation payable to persons entitled to Personal Coverage is subject to the same cost of living adjustments as compensation payable to other persons.

For policy regarding workers with multiple employments who have purchased Personal Coverage for at least one of those employments, see Item C9-65.00.

D. WORKERS WITH NO EARNINGS

Section 212 is an exception to both general rules for determining average earnings. There is no 10-week average earnings review.

Generally, persons working without pay are not considered as "workers" under the *Act*. However, there are some exceptional situations for which persons working without pay are covered and for which the *Act* or the Board has specified the earnings on which compensation is to be based.

The Board determines average earnings for a worker with no earnings at the time of injury in a manner that most accurately reflects the worker's earning capacity and loss of earnings at the time of injury, while considering the merits and justice of the particular case. Relevant factors in determining the worker's average earnings may include, but are not limited to, the following:

- the worker's employment and earnings history;
- the worker's current attachment to the labour force;
- whether the worker has received or is receiving wage-loss, or wage-loss equivalency, benefits; and
- the amount of average earnings determined on any previous claims.

Some situations where a person working without pay is covered are described in subsections i-iii below.

i. Volunteer Firefighters

The average earnings of volunteer firefighters working without remuneration is deemed to be the same in amount as the average earnings in their regular employment or employments, not, however, to be less than the amount on which the employer has been assessed (Item AP1-1-1 of the *Assessment Manual*).

In order to provide a minimum level of coverage to volunteer firefighters who have no attachment to the labour force, the employer is assessed $75.00 per month ($17.30 per week) for each person, unless the employer concerned has arranged with the Board for, or pays the claimant, a higher amount. Compensation is based on this rate unless or until wages are confirmed as being lost at another job. In the latter case, the rate can be increased to the rate on the job, but the $17.30 cannot be combined with it.

If the volunteer firefighter is unemployed, but has an attachment to the labour force in the sense that the volunteer firefighter is seeking employment, wage-loss benefits are determined on the average earnings from the last regular employment. The fact that the volunteer firefighter is collecting Employment Insurance benefits confirms for compensation purposes an attachment to the labour force. The 12 months immediately preceding the volunteer firefighter's date of injury will be used to determine the amount of wage-loss benefits to be paid. See Item C9-68.00 with respect to employment insurance income and the composition of average earnings.

If a volunteer firefighter is paid wages by the fire brigade these can be combined with earnings from another job, but not to exceed the maximum wage rate.

Volunteer firefighters who have no attachment to the labour force such as a retired person or someone in receipt of welfare payments would not generally have a loss of

wages as a result of an injury. Claims for these individuals are paid on the basis of a $75.00 per month assessment figure or greater where the employer arranges a higher valuation on the volunteer services.

There will be circumstances which do not fall squarely within these guidelines. When that occurs, the decision on what best represents the loss of earnings must be decided upon by the Board according to the merits and justice of the particular case.

Firefighters, other than those referred to in the policies in Items AP1-1-1 and AP5-245-2 of the *Assessment Manual* or firefighters whose employers are not covered by the compensation provisions of the *Act*, but to whom Personal Coverage has been given, are to be assessed and paid on the same basis as above.

ii. Sisters in Catholic Institutions

Claims are occasionally received for teaching or nursing sisters of Catholic institutions. If they are being paid wages they are treated as regular workers and compensated on the basis of their actual earnings. If no wages are being paid, their earnings are deemed to equal the amount on which their employers are assessed. This amount is $75.00 per month ($17.30 per week) for each person.

iii. Emergency Volunteers

Average earnings used in claims by emergency volunteers covered by the agreement between Canada and British Columbia pursuant to the *Emergency and Disaster Management Act* are based on the earnings in the worker's ordinary employment, but where the worker has no regular employment are fixed by the Board at a figure not less than $25.00 per week nor more than the maximum under the *Act* (Item AP1-5/6/7-1 of the *Assessment Manual*).

E. WORKERS IN PUBLIC INTEREST UNDERTAKING

Section 213 of the *Act* provides that if a person who is deemed to be a worker under section 5 *[extending application: public interest undertakings]* of the *Act*, is not regularly employed, the Board may, on the terms and conditions the Board directs, fix the amount of a person's average earnings having regard to all the circumstances, including the person's income, at not less than the amount set out below per week nor more than the maximum wage rate provided under section 209 of the *Act*.

January 1, 2025	—	December 31, 2025	$167.24
January 1, 2026	—	December 31, 2026	$170.86

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

In determining average earnings under section 213, the Board may apply the same factors which are considered in the determination of average earnings for workers with no earnings at the time of injury, as well as any terms and conditions of the coverage extended under section 5 of the *Act*.

The minimum wage set out above is subject to cost of living adjustments as described in Item C7-51.00.

EFFECTIVE DATE: July 4, 2025

AUTHORITY: Sections 1, 4, 212, 213, 214, 215, 219, and 243 of the *Act*.

CROSS REFERENCES:
Item C2-4.10, *Coverage for Volunteer Firefighters*;
Item C5-33.10, *Wage-Loss Benefits During Temporary Total Disability*;
Item C5-33.20, *Wage-Loss Benefits For Temporary Partial Disability*;
Item C6-37.00, *Permanent Total Disability Benefits*;
Item C6-39.00*, Section 195 Permanent Partial Disability Benefits*;
Item C7-51.00, *Cost of Living Adjustments to Periodic Payments;*
Item C9-65.00, *General Rule for Determining Short-Term Average Earnings*;
Item C9-68.00, *Composition of Average Earnings*;
Item C9-71.00, *Average Net Earnings*;
Item C16-111.10, *Third Party Claims – Injury Not Caused by Worker or Employer*;
Item C16-111.11, *Third Party Claims – Pursuing of Subrogated Actions by the Board*, of the *Rehabilitation Services & Claims Manual*, Volume II.
Item AP1-1-1, *Coverage under the Act – Determining Workplace Status*;
Item AP1-4-3, *Personal Coverage*; and
Item AP5-245-2, *Assessable Payroll*, of the *Assessment Manual.*

HISTORY:
March 2, 2026 – Housekeeping change to update the term “Personal Optional Protection” to “Personal Coverage.”
December 1, 2025 − Housekeeping change to update internal cross-reference, consequential to reformatting and renumbering Chapter 7, *Protection of and Deductions from Benefits*.
July 4, 2025 − This policy consolidates former policy items #67.00, #67.10, #67.20, #67.30, #67.31, #67.32, #67.33, #67.34, of the *Rehabilitation Services & Claims Manual,* Volume II, and adds guidance for workers with a casual pattern of employment, workers with no earnings at time of injury, and workers in public interest undertakings, consequential to reformatting and renumbering the policies in Chapter 9.
January 1, 2023 − Consequential changes related to the consolidation of policies on determining workplace status were made effective.
January 1, 2021 − Housekeeping changes made to cross-references consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. May 16, 2019 – Policy amended in accordance with changes to the *Act* resulting from the *Workers Compensation Amendment Act, 2019*, Bill 18 of 2019; which amended the definition of firefighter in section 1 of the *Act*, removing the reference to ambulance driver or attendant and to firefighters serving a municipality.
June 1, 2009 – Deleted references to Board officer and decision-maker.

January 1, 2006 – Amended to clarify that, when determining whether a worker's pattern of employment was casual in nature, the decision-maker should consider both the job at the time of the injury and the worker's pattern of employment. Policy also amended to include the types of factors decision-makers should consider.
March 18, 2003 – Policy amended as to where the maximum and minimum wage rate figures may be obtained. Inserted references from then Items AP1-1-5 and AP1-38-2 in the *Assessment Manual.*

APPLICATION: Applies to all decisions made on or after July 4, 2025.

RE: Exceptions to General Rule – Long-Term Average Earnings **ITEM: C9-67.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the statutory exceptions to the general rule for determining long-term average earnings: a worker who is an apprentice or learner, a regular worker who has been employed less than 12 months, and a worker with exceptional circumstances.

2. The Act

Section 1, in part:

> "worker" includes the following:
>
> …
>
> (b) person who
>
> (i) is a learner who is not under a contract of service or apprenticeship, and
>
> (ii) becomes subject to the hazards of an industry within the scope of the compensation provisions for the purpose of undergoing training or probationary work specified by the employer as a preliminary to employment;
>
> …

Section 216:

> (1) This section applies to a worker who, at the time of injury, was
>
> (a) an apprentice in a trade, occupation or profession, or
>
> (b) a person referred to in paragraph (b) *[training preliminary to employment]* of the definition of "worker" in section 1.
>
> (2) If a worker's injury results in a temporary disability that continues after the initial payment period, the Board must, for the period starting after the end

of the initial payment period, determine the amount of the worker's average earnings based on the greater of the following:

(a) the rate at which the worker was remunerated by each of the employers for whom the worker was employed at the time of the injury;

(b) the worker's gross earnings, as determined by the Board, for the 12-month period immediately preceding the date of injury.

(3) If a worker's injury results in a permanent disability, the Board must, for the period starting on the date, as determined by the Board, that the injury resulted in a permanent disability, determine the amount of the worker's average earnings based on the gross earnings, as determined by the Board, for the 12-month period immediately preceding the date of injury, of a qualified person employed at the starting rate in the same trade, occupation or profession

(a) by the same employer, or

(b) if no person is so employed, by an employer in the same region.

Section 217:

(1) This section applies to a worker who was employed, on other than a casual or temporary basis, by the worker's employer for less than 12 months immediately preceding the date of the injury.

(2) The Board's determination of the amount of the worker's average earnings under section 211 *[long-term compensation]* must be based on the gross earnings, as determined by the Board, for the 12-month period immediately preceding the date of injury, of a person of similar status employed in the same type and classification of employment

(a) by the same employer, or

(b) if no person is so employed, by an employer in the same region.

Section 218:

(1) If exceptional circumstances exist such that the Board considers that the application of section 211 would be inequitable, the Board's determination of the amount of a worker's average earnings may be based on an amount that the Board considers best reflects the worker's loss of earnings.

(2) Subsection (1) does not apply in the circumstances described in section 214, 215, 216 or 217.

Section 219:

See Item C9-67.00.

POLICY

A. APPRENTICE OR LEARNER

Section 216 is an exception to the general rule for determining long-term average earnings.

The Board generally considers that an "apprentice in a trade" is an apprentice as defined under the terms and conditions in the provincial *Skilled Trades BC Act* or equivalent statute. The *Industry Training Regulation* or equivalent provides a list of trades that require compulsory certification. Usually, the Board requires some form of proof that a worker is registered as an apprentice in a trade, either with SkilledTradesBC, a union, or another official training agency.

The Board generally considers that an "apprentice in an occupation or profession" is a worker who must complete an "apprenticeship" in order to obtain the license or professional designation required to work in the occupation or profession.

In most cases, the worker should be employed under a contract of apprenticeship in a trade, occupation or profession at the time of injury.

Section 216 of the *Act* includes a worker referred to in paragraph (b) of the section 1 definition of "worker".

The Board considers that a learner is a person who is undergoing training or probationary work that is preliminary to employment. The training or probationary work must be required by the employer and makes the person subject to the hazards of an industry covered by the compensation provisions of the *Act*. A person is not a learner when the person is under a contract of service or an apprenticeship.

If the Board determines a worker is an apprentice or learner, the section 216 exception will apply to the determination of their long-term average earnings. If a worker's injury results in a temporary disability that continues after the initial 10-week payment period, the Board determines the amount of the worker's average earnings in accordance with section 216(2), based on the greater of:

(a) the rate at which the worker was remunerated by each of the employers for whom the worker was employed at the time of the injury; or

(b) the worker's gross earnings, as determined by the Board, for the 12-month period immediately preceding the date of injury.

If a worker's injury results in a permanent disability, the Board determines the amount of the worker's average earnings in accordance with section 216(3) of the *Act*.

The Board will contact the injury employer to determine what a qualified person employed at the starting rate in the same trade, occupation or profession earns or would earn with the injury employer for the relevant 12-month period. The Board may use information about the starting rate of a worker currently employed by the injury employer, or previously employed by the injury employer in the 12-month period immediately preceding the worker's date of injury, who has completed the same apprenticeship or the same training and probationary work in which the injured worker was engaged.

If this information is not available, the Board will contact an employer similar to the injury employer, in the same region as the injury employer, to determine what a qualified person employed at the starting rate in the same trade, occupation or profession earns.

The Board is not limited to obtaining wage rate information from a single employer. As such, the Board may use information from sources such as BC Stats and Statistics Canada, as well as from employers in the region on the average starting rate of various trades, occupations and professions. This information may be used to determine the average earnings of an apprentice or learner where relevant information is not available from the worker's employer.

The average earnings determined in accordance with section 216(3) of the *Act* apply as of the date the Board determines that the worker's injury has resulted in a permanent disability. The earnings will be used to calculate a worker's entitlement to permanent disability benefits. It will also be used to calculate wage-loss equivalency payments while a worker participates in a vocational rehabilitation plan.

B. WORKERS EMPLOYED LESS THAN 12 MONTHS

Section 217 is a mandatory exception to the general rule for determining long-term average earnings and applies to a worker with permanent employment.

To determine a worker's average earnings under section 217 of the *Act*, the Board will contact the injury employer to determine what the average earnings are or would be of a person of similar status employed in the same type and classification of employment. The Board may use information about a similar status worker currently employed by the injury employer, or previously employed by the injury employer in the 12-month period immediately preceding the worker's date of injury.

If this information is not available, the Board will contact an employer similar to the injury employer, in the same region as the injury employer, to determine what the average

earnings are of a person of similar status employed in the same type and classification of employment.

The Board is not limited to obtaining wage rate information from a single employer. As such, the Board may use information from sources such as BC Stats and Statistics Canada, as well as from employers in the region on the average earnings of a person of similar status employed in the same type and classification of employment. This information may be used to determine the average earnings of a worker who has worked less than 12 months for the injury employer where relevant information is not available from the worker's employer.

Some factors in determining whether a worker is of similar status to the injured worker include having the same or similar:

- hours worked;
- job description;
- job responsibilities;
- rate of pay;
- training;
- employment status (full-time or part-time employment)
- length of employment; or
- union status and/or being subject to the same collective agreement.

No single factor is determinative. Relevant factors not listed in policy may also be considered.

C. EXCEPTIONAL CIRCUMSTANCES

Section 218 is a discretionary provision and an exception to the application of section 211 for determining a worker's long-term average earnings. As such, it will only be applied if the Board considers that, due to exceptional circumstances, the application of section 211 is inequitable.

As stated in section 218(2), this provision does not apply to the following:

- a casual worker;
- a person who purchased coverage under section 4(2) of the Act;

- a worker determined by the Board to be an apprentice or a learner; or
- a permanently employed worker who has been employed by the employer for less than 12 months.

The purpose of this policy is to assist in identifying inequities where due to exceptional circumstances the level of compensation calculated using the general rule does not best reflect the worker's long-term loss of earnings.

In making this determination, "best" does not mean the highest level of compensation possible, but rather, that the level of compensation reflects the actual loss incurred by the worker.

The general rule uses one year of a worker's earnings history to account for typical variations in earnings. Short absences from work for non-compensable reasons, minor fluctuations in hours worked or rate of pay, or similar reasons for changes to earnings are typical and will not be considered exceptional circumstances.

The following are circumstances that are generally accepted as being exceptional circumstances affecting a worker's average earnings. This list is not exhaustive. The Board may consider other reasons to find that exceptional circumstances exist, if those reasons are consistent with the *Act* and the purpose of this policy:

(a) Any prior period(s) when a worker received wage-loss benefits (or wage-loss equivalent rehabilitation allowances/benefits) during the 12-month period immediately preceding the worker's date of injury. The Board considers it inequitable to reduce a worker's average earnings by including periods of wage-loss benefits (or wage-loss equivalent rehabilitation allowances/benefits) in the average earnings calculation.

- This circumstance may arise, for example, if a worker has received temporary total disability wage-loss benefits, temporary partial disability wage-loss benefits, vocational rehabilitation training allowance or other types of wage-replacement benefits.

The Board excludes any periods during which the worker received wage-loss benefits (or vocational rehabilitation wage-loss equivalent rehabilitation allowances/benefits) from the total period over which earnings are averaged. In some cases, the Board may use a shorter or longer period of the worker's employment history to determine what best reflects the worker's average earnings.

(b) The Board determines that the worker has a regular pattern of employment, and that the worker's earnings in the 12-month period immediately preceding the date of the injury do not reflect the worker's

historical earnings because of a significant atypical and/or irregular disruption in the pattern of employment during that period of time.

- This circumstance may arise, for example, if the worker has had an absence of more than six consecutive weeks in the 12-month period immediately preceding the date of injury and the absence was due to a non-compensable illness or injury, educational or maternity/paternity reasons.

In such cases, the Board may deduct the period of the absence. In addition, the Board may use a shorter or longer period of the worker's employment history (e.g., 24-month period) to determine long-term average earnings.

(c) The Board is satisfied that the worker's earnings in the 12-months immediately preceding the date of injury do not address the worker's diminished future career options because of the nature and degree of the injury.

- This circumstance may arise, for example, if the worker is a student on a designated path of study at a provincially recognized training or educational institution and was in temporary employment unrelated to the worker's field of study (e.g. a part-time or seasonal job) at the time of the injury. Due to the nature and degree of the injury, the worker is unable to continue in the worker's chosen field of study.

In such cases, the Board may determine the worker's long-term average earnings with reference to the class average of a qualified person in an occupation directly related to the worker's field of study.

- This circumstance may also arise if the worker is under the age of 25 (BC Stats defines youths as individuals aged 15 to 24) and has completed a designated course of study at a provincially recognized training or educational institution in the two years immediately preceding the date of injury. Due to the worker's young age, the employment at the time of injury may not be representative of the worker's career path, as provided for by the worker's recent course of study.

In such cases, the Board may determine the worker's long-term average earnings with reference to the class average of a qualified person in an occupation related to the young worker's previous field of study.

(d) Deductions must be made from the worker's gross income to derive the labour component of the worker's average earnings.

- This circumstance may arise if the worker is self-employed and receives remuneration based, in part, on operating costs or expenses that must be deducted from the worker's gross business income to obtain the worker's average earnings (e.g., costs for purchasing, operating or maintaining major equipment).

In such cases, the Board may consider the worker's earnings history for a longer time period in order to incorporate information required to accurately determine the worker's long-term average earnings.

EFFECTIVE DATE:	July 4, 2025
AUTHORITY:	Sections 1, 216, 217, 218, and 219 of the *Act*.
CROSS REFERENCES:	Item C9-65.00, *General Rule for Determining Short-Term Average Earnings*; Item C9-66.00, *General Rule for Determining Long-Term Average Earnings*; and Item C9-67.00, *Exceptions to General Rules – Short-Term and Long-Term Average Earnings*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	July 4, 2025 – This policy consolidates former policy items #67.40, #67.50, and #67.60 of the *Rehabilitation Services & Claims Manual*, Volume II, and adds guidance on apprentices, learners, and workers employed less than 12 months, consequential to reformatting and renumbering the policies in Chapter 9. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. May 1, 2008 – Policy amended to ensure decision-makers are not limited to considering only the criteria set out in the policy when determining whether exceptional circumstances exist; prior periods of wage-loss compensation also expressly included.
APPLICATION:	Applies to all decisions made on or after July 4, 2025.

RE: Composition of Average Earnings **ITEM: C9-68.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on what types of payments are included in, or excluded from, the composition of average earnings.

2. The Act

Section 208, in part:

…

(3) The Board must not include the following in determining the amount of a worker's average earnings:

(a) the employer's payments on behalf of the worker for

(i) contributions payable under the *Canada Pension Plan*,

(ii) premiums payable under the *Employment Insurance Act* (Canada), and

(iii) contributions to a retirement, pension, health and welfare, life insurance or other benefit plan for the worker or the worker's dependants;

(b) special expenses or allowances paid to the worker because of the nature of the worker's employment.

(4) If income from employment benefits was payable to a worker under the *Employment Insurance Act* (Canada) during the period for which average earnings are to be determined, the Board may include that income in the determination only if the Board considers that the worker's employment during that period was in an occupation or industry that results in recurring seasonal or recurring temporary interruptions of employment.

(5) The compensation payable to workers who, on July 1, 1974, receive compensation for permanent total disability must not be less than $2,174.27 per month.

POLICY

A worker's average earnings are normally composed of wages or salary. However, the Board recognizes that a worker may receive other types of payments. This policy sets out the treatment of specific types of payments.

A. EXTRAORDINARY OR IRREGULAR WAGE PAYMENTS

Such items as commission, piecework, bonus, tips and gratuities must be included in a worker's average earnings where the Board can verify the information provided to the Board, including through independent sources. Where wages paid to a worker are supplemented by an additional amount representing statutory holiday payments or vacation allowances, these additional amounts are included in a worker's average earnings.

i. Overtime

Only regular overtime is included in the calculation of a worker's average earnings.

ii. Severance or Termination Pay

Severance or termination pay received by a worker is not included in the calculation of average earnings.

iii. Salary Increases

In calculating average earnings, no regard will normally be paid to salary increases or promotions which a worker might have received if the injury had not occurred. The only exception is where a salary increase is awarded which is retroactive to before the injury.

B. EMPLOYMENT BENEFITS

i. Benefit Plans

The Board does not include employment benefits listed under section 208(3)(a) as a component of average earnings. These employment benefits are the employer's payments on behalf of the worker for contributions payable under the *Canada Pension Plan*, premiums payable under the *Employment Insurance Act* (Canada), and contributions to retirement, pension, health and welfare, life insurance or other benefit plans for the worker or the worker's dependants.

For the purpose of section 208(3)(a)(iii), the Board considers that payments made by the employer on behalf of the worker for contributions to a retirement plan include any contributions to a cashable Registered Retirement Savings Plan.

ii. Room and Board

Provision of room includes free or subsidized lodging. Provision of board includes free or subsidized food and meals. The dollar value of room and board or an allowance in lieu of room and board that is provided by an employer as part of a worker's remuneration is included in the calculation of average earnings. This includes any payment made by the worker for the continuation of room and board while disabled.

Room and board which is paid to the worker in total or in part by an employer as the remuneration for services rendered is included in average earnings. Room and board incurred as a business expense by the employer is not included in average earnings.

One example of a business expense is where a worker makes a business visit out of town and incurs the cost of hotel and meals. On return, the worker submits an expense account and the actual expenses are refunded by the employer. Another example of a business expense is where room and board is provided to a worker at a remote worksite.

In situations where room and board is incurred as a business expense, the Board does not consider the expenses when calculating a worker's average earnings because the expenses are not remuneration for services rendered but rather incidental to the worker performing employment duties.

A situation where the provision of room is considered remuneration is for resident caretakers of apartment buildings. The value of any free or subsidized apartment provided with the job is considered when determining average earnings. If specific evidence is not available, relevant sources, including section 17 of the *Employment Standards Regulation*, may be referred to when valuing an apartment.

Where a worker continues to be provided with room and board during the disability without extra charge and the worker's salary is continued by the employer, any reimbursement to the employer carried out by the Board will, subject to the maximum wage rate under the *Act*, include the value of room and board as well as the worker's salary.

If an employer withdraws room and board during the disability, that portion of wage-loss benefits representing the dollar value of the room and board would be paid directly to the worker.

iii. Special Expenses or Allowances

Although a worker may receive payments in respect of work-related expenses or allowances, these payments will not be included in the calculation of average earnings.

Examples of special expenses or allowances include:

- tool allowances paid to tradespersons;
- safety boot allowances provided to workers required to wear safety boots due to the nature of their work;
- clothing allowances for workers required to wear special apparel for their work;
- dry-cleaning allowances;
- vehicle allowances; and
- travel allowances.

C. STRIKE PAY

Strike pay is not included when calculating a worker's average earnings.

D. EMPLOYMENT INSURANCE PAYMENTS

Section 208(4) is a discretionary provision and will be applied only where the evidence supports a finding that the worker received employment insurance benefits due to the worker's employment in an occupation or industry that results in recurring seasonal or recurring temporary interruptions of employment.

An occupation or industry with recurring seasonal interruptions is one in which there are reduced opportunities for employment at the same or similar time every year. An occupation or industry with recurring temporary interruptions is one in which there is a pattern of temporary periods of reduced opportunities for employment in successive years. Generally, recurring seasonal and temporary interruptions result from inherent operational factors, including weather conditions or the cyclical nature of the occupation or industry.

The Board may collect the necessary data to compile a list of industries and occupations that result in recurring seasonal or recurring temporary interruptions of employment. The list must give regard to regional considerations and may adopt information from sources such as BC Stats, Statistics Canada or the department continued under the *Department of Employment and Social Development Act* (Employment and Social Development Canada – "ESDC").

E. PROPERTY VALUE LOSSES

No account will be taken of losses in property values alleged to be the result of the work injury, for example, where the injured person is disabled from working on and improving

land which the person owns or there is a loss of goodwill in the business because of an inability to work in it.

F. PAYMENTS TO SUBSTITUTES

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

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

Where a worker has Personal Coverage, wage-loss benefits are calculated without regard to the fact that the worker is employing a substitute to do all the pre-injury work.

G. GOVERNMENT SPONSORED WORK PROGRAMS

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

1. The simple continuation of Employment Insurance, Welfare or other benefits.

2. A "top-up" of Employment Insurance, Welfare or other benefits.

3. Full payment by the employer, subsidized either in whole or in part from Employment Insurance, Welfare or other government funds.

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

EFFECTIVE DATE:	July 4, 2025
AUTHORITY:	Section 208 of the *Act*.
CROSS REFERENCES:	Item C5-34.10, *Payment of Wage-Loss Benefits*; Item C9-68.10, *Composition of Average Earnings – Deducting Business or Equipment Expenses*; and Item C9-68.20, *Composition of Average Earnings – Principals*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	March 2, 2026 – Housekeeping change to update the term "Personal Optional Protection" to "Personal Coverage." July 4, 2025 – This policy consolidates former policy items #68.00, #68.10, #68.11, #68.12, #68.13, #68.20, #68.21, #68.22, #68.23, #68.30, #68.40, #68.50, #68.70, #68.80 of the of the *Rehabilitation Services & Claims Manual*, Volume II, and adds guidance on benefit plans, room and board, and employment insurance payments, consequential to reformatting and renumbering the policies in Chapter 9. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Policy amended to provide guidance on the legal issues of standard of proof and evidence. June 1, 2009 – Updated reference to Human Resources and Skills Development Canada.
APPLICATION:	Applies to all decisions made on or after July 4, 2025.

RE: Composition of Average Earnings – Deducting Business or Equipment Expenses **ITEM: C9-68.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on how to treat deductions for business or equipment expenses when determining the composition of a worker's average earnings.

2. The Act

Section 208:

See Items C9-64.00 and C9-68.00.

POLICY

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

A. WORKERS DEDUCTING BUSINESS AND/OR EQUIPMENT EXPENSES

Section 208(1) of the *Act* provides that the Board must determine the amount of a worker's average earnings and the worker's earning capacity with reference to the "worker's average earnings and earning capacity at the time of the worker's injury."

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

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

Generally, where a worker may deduct business expenses and/or costs associated with equipment from the worker's earnings for business or tax purposes, this suggests that the worker's earnings include payment in respect of such costs and/or expenses. This policy does not apply to a worker receiving separate special expense reimbursements

or allowances from an employer; the Board considers such payments under Item C9-68.00.

(a) Short-Term Average Earnings

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

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

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

(i) Light Equipment

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

Equipment	**Wages**
15%	85%

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

(ii) Medium Equipment

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

Equipment	**Wages**
40%	60%

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

(iii) Heavy Equipment

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

Equipment	Wages
75%	25%

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

(b) Long-Term Average Earnings

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

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

1) Did the worker's gross earnings for the time period under review include payment in respect of the expense?

2) Did the worker incur the expense directly as a result of supplying equipment and/or materials to the employer?

3) Did the expense result from the worker operating the worker's business?

4) Would the worker incur the expense regardless of the nature of the employment?

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

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

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

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

Interest accrued (whether paid or not) as the result of debt in respect of equipment owned by a worker that is a required component of the contract of service is considered a business expense. The accrued interest is deducted from gross income.

B. FISHERS

Generally, where a fisher may deduct business expenses and/or costs associated with equipment from the fisher's earnings for business or tax purposes, this suggests that the fisher's earnings include payment in respect of such costs. In calculating the earnings of a fisher who, for business or taxation purposes, deducts business expenses and/or costs associated with equipment, the Board decides which costs and/or expenses will be deducted from gross earnings to determine the labour component of the fisher's gross earnings. This policy does not apply to a fisher receiving separate special expense reimbursements or allowances from an employer; the Board considers such payments under Item C9-68.00.

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

1) Did the fisher's gross earnings for the time period under review include payment in respect of the expense?

2) Did the fisher incur the expense directly as a result of supplying equipment and/or materials for fishing activities?

3) Did the expense result from the fisher operating their business?

4) Would the fisher incur the expense regardless of the nature of the employment?

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

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

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

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

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

The purchase of food as a business expense is not deducted from gross income as it is considered a direct benefit to the fisher and is a measurable return from the activities of fishing. The costs of maintenance for the vessel or other equipment used to harvest fish, fuel, fishing nets, and other appropriate costs are deducted from gross income as costs associated with equipment. See also Item C9-65.00.

EFFECTIVE DATE:	July 4, 2025
AUTHORITY:	Section 208 of the *Act*.
CROSS REFERENCES:	Item C9-68.00, *Composition of Average Earnings*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	July 4, 2025 – This policy consolidates former policy items #68.60, #68.61, #68.62, of the *Rehabilitation Services & Claims Manual,* Volume II, consequential to reformatting and renumbering the policies in Chapter 9. June 1, 2024 − Housekeeping changes made to modernize terminology by removing gendered language. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
APPLICATION:	Applies to all decisions made on or after July 4, 2025.

RE: Composition of Average Earnings – Principals **ITEM: C9-68.20**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on determining the composition of average earnings for principals.

2. The Act

Section 208:

See Items C9-64.00 and C9-68.00.

POLICY

The *Assessment Manual* sets out who may be a principal, and criteria for determining whether a principal is a worker. Principals' average earnings are calculated based on earnings from employment, including earnings shown on official statements issued by the firm for income tax purposes and management fees. When determining the composition of a principal's average earnings, the Board may consider dividends and the repayment of a principal's loan to the employer as earnings in cases where it is shown that the amount received by the principal represents payment for the principal's labour.

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

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

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

EFFECTIVE DATE:	July 4, 2025
AUTHORITY:	Section 208 of the *Act*.
CROSS REFERENCES:	Item C9-68.00, *Composition of Average Earnings*; and Item C9-68.10, *Composition of Average Earnings – Deducting Business or Equipment Expenses*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	July 4, 2025 – Former policy item #68.90 of the *Rehabilitation Services & Claims Manual,* Volume II reformatted consequential to reformatting and renumbering the policies in Chapter 9. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Policy amended to provide guidance on the legal issues of standard of proof and evidence. January 1, 2008 – Amendments to provide principals will be compensated based on their actual average earnings, as most other workers are.
APPLICATION:	Applies to all decisions made on or after July 4, 2025.

RE: Maximum Amount of Average Earnings **ITEM: C9-69.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on statutory provisions on maximum wage rate.

2. The Act

Section 200:

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

(2) If a worker has received a lump sum in place of the periodic payments that otherwise would have been payable for a permanent disability, the worker is deemed, for the purposes of subsection (1), to still receive the periodic payments..

Section 208(2):

See Item C9-64.00.

Section 209:

(1) Before the end of each calendar year, the Board must determine the maximum wage rate applicable for the following calendar year.

(1.1) As an exception to subsection (1), the maximum wage rate for 2021 is $100 000.

(2) The maximum wage rate to be determined under this section must be an amount, which may be rounded to the nearest $100, that the Board considers represents the same relationship to the amount of $100 000 as

(a) the annual average of wages and salaries in British Columbia for the year preceding the year in which the determination is being made

bears to

(b) the annual average of wages and salaries in British Columbia for the year 2019.

(3) For the purpose of determining annual average of wages and salaries under this section, the Board may use data published or supplied by Statistics Canada.

POLICY

A. INTRODUCTION

Section 208(2) provides that a worker's average earnings cannot exceed the "maximum wage rate" as determined under section 209.

Section 209 of the *Act* contains a special procedure for determining the maximum wage rate in force in any year.

Prior to 2020, the *Act* referred to $40,000 and 1984 as the factors in the formula for calculating the maximum for the following calendar year. Prior to 1986, the *Act* referred to $11,200 and 1972 as the factors in the formula for calculating the maximum for the following calendar year.

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

	Yearly Applicable
January 1, 2025 – December 31, 2025	$121,500.00
January 1, 2026 – December 31, 2026	$127,500.00

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

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

Increases in the maximum wage rate do not have the effect of increasing the existing compensation being paid to workers whose payments have been limited by the lower maximum existing in a previous year. Exceptions to this rule may occur if, on a reopening occurring more than three years after a worker's injury, the Board exercises its authority under section 193 or section 197 to base the amount of compensation payable on the worker's earnings at the date of the reopening (See Item C9-70.00).

Authority to approve increases in the maximum wage rate under section 209 has been assigned to the President.

B. DEDUCTION OF PERMANENT DISABILITY PERIODIC PAYMENTS FROM WAGE-LOSS BENEFITS

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

For calculating the amount of a deduction, the daily rate of the permanent disability benefits must be determined and then deducted from the daily rate of wage-loss benefits in the manner set out in Item C9-70.00.

The deduction made under section 200 must be reviewed on each January 1 following the injury. This is to allow for possible cost of living adjustments to the amount of the permanent disability benefits and the wage-loss benefits and, with regard to January 1, changes in the maximum wage rate. For the purpose of section 200, the relevant maximum is the one applying in the year in which the wage-loss benefits payment is being made.

For the deduction from wage-loss benefits of permanent disability benefits under the same claim, reference should be made to Item C9-70.00.

i. Permanent Disability Lump Sum Compensation

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

In the case of a reopening of the same claim within three years, any previous lump-sum payment (in place of a permanent disability periodic payment) will be deducted from the current daily wage-loss benefit payments. The same position exists in respect of reopenings of the same claim after three years where the worker's pre-injury earnings

are used to calculate benefits. If, however, in the case of a reopening after three years, wage-loss benefits for a recurrence of temporary disability are based on the worker's current earnings under the terms of sections 193(1) and 193(2), any previous lump-sum payment (in place of a permanent disability periodic payment) will not be deducted in accordance with section 193(3), except to the extent that the combined total exceeds the maximum wage rate in effect at the time of the recurrence.

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

EFFECTIVE DATE:	July 4, 2025
AUTHORITY:	Sections 200, 208, and 209 of the *Act*.
CROSS REFERENCES:	Item C6-45.00, *Lump Sums and Commutations*; and Item C9-70.00, *Average Earnings on Reopened Claims*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	July 4, 2025 – This policy consolidates former policy items #69.00, #69.10, #69.11, of the *Rehabilitation Services & Claims Manual,* Volume II, consequential to reformatting and renumbering the policies in Chapter 9. April 3, 2023 − Housekeeping amendment. January 1, 2021 – Housekeeping changes made to cross-references consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*. October 21, 2020 – Amended to reflect amendment to the maximum wage rate provisions of the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020. September 1, 2020 – Policy amended to remove a spent provision, and reverse a housekeeping change. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
APPLICATION:	Applies to all decisions made on or after July 4, 2025.

RE: Average Earnings on Reopened Claims **ITEM: C9-70.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on determining average earnings on reopened claims and whether to use original or current earnings to calculate compensation payable on claims reopened after 3 years from the injury date.

2. The Act

Section 193:

(1) This section applies if there is a recurrence of temporary total disability or temporary partial disability of a worker after a lapse of 3 years following the occurrence of the injury to the worker.

(2) For the purpose of determining the amount of compensation payable to the worker, the Board may calculate the compensation as if the date of the recurrence was the date of the injury if the Board considers that, by doing so, the compensation payable would more closely represent the percentage of actual loss of earnings of the worker by reason of the recurrence of the injury.

(3) Subject to subsection (4), if

(a) a worker receives compensation for permanent partial disability for the original injury, and

(b) compensation for recurrence of temporary total disability under subsection (2) is calculated by reference to the average earnings of the worker at the date of the recurrence,

the compensation under this section must be calculated without deduction of the compensation payable for the permanent partial disability.

(4) The total compensation payable under this section must not be greater than the maximum payable under this Part at the date of the recurrence.

Section 197:

(1) This section applies if, more than 3 years after a worker's injury,

(a) a permanent disability resulting from the injury occurs, or

(b) an increased degree of permanent disability resulting from the injury occurs.

(2) Despite section 208 (1) *[determination of average earnings as at time of injury]*, the Board may calculate the compensation by reference to the average earnings of the worker at the date of the occurrence of the permanent disability or increased degree of permanent disability, as applicable.

POLICY

A. DISABILITY OCCURRING WITHIN THREE YEARS OF INJURY

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

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

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

1. The annual permanent disability payment amount is calculated by multiplying the monthly figure by 12.

2. The annual permanent disability payment amount is divided by the working days per year to obtain a daily rate.

5-day week	=	261 days
5-1/2-day week	=	287 days
6-day week	=	313 days
7-day week	=	365 days

3. The daily permanent disability payment amount is deducted from the daily wage-loss benefits payment (See Item C9-69.00).

If a 10-week rate review has not already been carried out on the claim and one is required, it will be done by the Board officer following the reopening at the earlier of: when the total wage-loss benefits paid on the claim add up to ten weeks or the effective date of permanent disability benefits.

B. REOPENINGS OVER THREE YEARS

This policy sets out how the Board determines compensation benefits if a worker's claim is reopened because the worker's temporary disability recurs, or a permanent disability occurs or increases, more than three years after the date of the original compensable injury.

If a temporary disability recurs more than three years after the original injury, section 193(2) of the *Act* gives the Board the discretion to calculate a worker's compensation as if the recurrence were the date of the injury. This means the Board may use the worker's earnings at the time of the recurrence to calculate compensation benefits. The date used by the Board to determine whether more than three years have passed since the original injury, is the date the worker first experiences a loss of earnings, or potential loss of earnings, due to the recurrence of temporary disability.

If a permanent disability occurs or increases in degree more than three years after the worker's original injury, section 197 of the *Act* applies. This means the Board may use the worker's earnings at the time that the permanent disability occurs or increases in degree to calculate benefits. The date used by the Board to determine whether more than three years have passed since the original injury is the date the permanent disability occurs or increases in degree.

1. DETERMINING EARNINGS USED TO CALCULATE COMPENSATION PAYABLE

To determine the earnings used to calculate compensation payable on a reopening of a claim more than three years after the injury, the Board uses those earnings that most

closely represent the actual, or potential, loss of earnings of the worker as a result of the recurrence of temporary disability, or occurrence or increase in permanent disability, while considering the merits and justice of the particular case. The Board compares:

- the worker's earnings at the date of the original injury, with applicable cost of living adjustments; and
- the worker's current earnings at the date of the recurrence of temporary disability or the occurrence or increase in degree of permanent disability.

When comparing a worker's earnings, the Board looks at the average earnings originally set on the claim. If long-term average earnings were previously set, the Board compares those earnings to the worker's current short-term average earnings, or if applicable, current long-term average earnings, which are determined in accordance with sections 210 to 219 of the *Act*. If no long-term average earnings were originally set on the claim, then the short-term average earnings are used to make the comparison.

If the original earnings on the claim were set before June 30, 2002, it may be necessary to recalculate those earnings to convert them from 75% of gross average earnings to 90% of average net earnings. This conversion involves using the worker's earnings at the date of the original injury plus applicable cost of living adjustments, and the relevant tax provisions at the date of the recurrence of the temporary disability or at the date the permanent disability occurs or increases in degree.

Cost of living adjustments that occur pursuant to section 334(3) of the *Act* in the first twelve months following the recurrence of the temporary disability, or increase or occurrence of the permanent disability, are not applicable to compensation benefits calculated in accordance with this policy.

1.1 Current Earnings are Higher than Original Earnings

If a worker's current earnings are higher than the original earnings, the current earnings will be used to calculate compensation payable.

1.2 Current Earnings are Lower than Original Earnings

If a worker's current earnings are lower than the original earnings, the Board determines whether an actual or potential loss of earnings is caused by the recurrence of temporary disability or occurrence or increase in permanent disability. In these cases, the Board will use the worker's earnings at the date of the original injury, plus the applicable cost of living adjustments, to calculate compensation benefits.

In determining if there is a potential loss of earnings, the factors the Board may consider include, but are not limited to, the following:

(a) If the worker is unemployed or has reduced earnings, is it likely that the worker would have found work or earned a higher income if not for the disability? If yes, this may indicate that there is a potential loss. However, if an economic downturn or other employment difficulties caused the worker's earnings to decrease, this may indicate there is no potential loss.

(b) If the worker is unemployed, does the worker's lifestyle render it unlikely that the worker will obtain employment? For example, if the worker moved to a remote area where there are limited employment opportunities, this may indicate that there is no potential loss.

(c) If the worker is unemployed, is the worker actively searching for a job? Has the worker registered with any provincial or federal government agencies to assist in the job search? If so, this may indicate there is a potential loss.

(d) Are there any other non-compensable health conditions or personal problems that limit the possibility for the worker to earn an increased income, or gain employment? If so, this may indicate that there is no potential loss.

(e) Has the worker maintained union status? If the worker has remained available for dispatch to jobs, or been dispatched to jobs, then this may indicate a potential loss. If the worker has declined offers of dispatch, this may indicate no potential loss.

(f) Was the worker recently on some form of worker's compensation or other disability benefit due to a different disability? Has the worker since recovered but not yet returned to work? If so, this may indicate a potential loss.

If a worker's current earnings are lower than the original earnings for reasons unrelated to the disability, the Board may use current earnings to calculate compensation benefits. Examples include, but are not limited to the following:

- If the worker has no current earnings for reasons unrelated to the disability accepted on the claim and there is no potential loss of earnings, then no wage-loss benefits are payable. In cases where a permanent disability occurs or increases in degree, the worker may be eligible for benefits under section 195(1) of the *Act*. If eligibility is established, the amount of permanent partial disability benefits is calculated on the basis of the worker's earnings at the date of the original injury, plus applicable cost of living adjustments.

- If the worker has reduced earnings for reasons unrelated to the compensable disability and the disability does not prevent the worker from earning an increased income, then compensation benefits are based on the worker's earnings at the date of the recurrence, or the occurrence or increase of degree of permanent disability.

1.3 Current Earnings are Equal to Original Earnings

If a worker's current earnings, and original earnings plus applicable cost of living adjustments, are equal, compensation benefits are based on the worker's current earnings.

1.4 Board Calculations when Current Earnings are Used

If the current earnings are used to calculate compensation benefits for a recurring temporary disability, the initial payment period provided in section 210 of the *Act* recommences.

2. WORKER RECEIVING PERMANENT PARTIAL DISABILITY BENEFITS FOR THE SAME DISABILITY

If wage-loss benefits for a recurrence of a temporary disability are based on the worker's current earnings and, if the worker receives permanent partial disability benefits in respect of the original injury, subsections 193(3) and 193(4) apply. Therefore, the permanent disability periodic payment is not deducted from the wage-loss benefits except to the extent that the combined total is greater than the maximum wage rate in effect at the time of the recurrence. (See also Item C9-69.00.)

3. PERSONS WITH PERSONAL COVERAGE

This policy applies to persons who purchased Personal Coverage at the date of the original injury and/or at the date of the recurrence of the temporary disability, or occurrence or increase in degree of the permanent disability.

Compensation benefits for such persons are calculated in accordance with this policy, except that the Board will use the amount of Personal Coverage purchased in determining the person's earnings.

If a worker is engaged in multiple employments at the time of reopening, the principles of Item C9-65.00 with respect to workers engaged in multiple employments apply to the Board's determination of compensation benefits.

4. PRIOR OCCASION WHEN SECTION 193 OR 197 WAS APPLIED

If, on a previous reopening of the claim, section 193 or 197 of the *Act* or their predecessors were used to base compensation on the worker's current earnings, any

rate resulting from the previous application of section 193 or 197 is ignored at the time of the later reopening.

C. PERMANENT DISABILITY BENEFITS

The Board's policy with respect to a reopening of claims after three years, where permanent disability lump sum compensation is involved, is as described in Item C9-69.00.

EFFECTIVE DATE:	July 4, 2025
AUTHORITY:	Sections 193 and 197 of the *Act*.
CROSS REFERENCES:	Item C9-69.00, *Maximum Amount of Average Earnings*; Item C14-102.01, *Changing Previous Decisions – Reopenings*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	March 2, 2026 – Housekeeping change to update the term "Personal Optional Protection" to "Personal Coverage." July 4, 2025 – This policy consolidates former policy items #70.00, #70.10, #70.20, and #70.30 of the *Rehabilitation Services & Claims Manual,* Volume II, and adds guidance on reopenings over three years consequential to reformatting and renumbering the policies in Chapter 9. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
APPLICATION:	Applies to all decisions made on or after July 4, 2025.

RE: Average Net Earnings **ITEM: C9-71.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the statutory provisions related to allowable deductions and calculating average net earnings.

2. The Act

Section 220:

(1) This section applies to the determination of the amount of a worker's average net earnings for the period under section 210 *[average earnings: short-term compensation]* that applies to the worker.

(2) The Board must estimate the following deductions for the calendar year immediately preceding the injury, based on the worker's average earnings as determined under Division 7 of this Part [Part 4 of the *Act* — Compensation to Injured Workers and Their Dependants]:

(a) premiums payable by a worker under the *Employment Insurance Act* (Canada);

(b) contributions payable by a worker under the *Canada Pension Plan*;

(c) probable income taxes payable by a worker under the *Income Tax Act* and the *Income Tax Act* (Canada).

(3) In order to determine the amount of a worker's average net earnings under this section, the Board must deduct the amounts estimated under subsection (2) from the worker's average earnings as determined under Division 7 of this Part [Part 4 of the *Act* — Compensation to Injured Workers and Their Dependants].

(4) For the purposes of this section, premiums and contributions referred to in subsection (2) (a) and (b) are deemed to be payable by all workers.

(5) To estimate probable income taxes for the purposes of this section, the Board must assume that the following are the only deductions that may be

made for a worker under the *Income Tax Act* and the *Income Tax Act* (Canada):

(a) the amounts that may be deducted under

(i) section 4.3 (1) (c) *[BC basic personal credit — single status]* of the *Income Tax Act*, and

(ii) section 118 (1) (c) *[equivalent]* of the *Income Tax Act* (Canada),

each multiplied by 1.5;

(b) the amounts that may be deducted under

(i) section 4.64 *[BC credit for EI premium and CPP contribution]* of the *Income Tax Act*, and

(ii) section 118.7 *[equivalent]* of the *Income Tax Act* (Canada).

Section 221:

(1) This section applies to the determination of the amount of a worker's average net earnings after the end of the applicable period referred to in section 220 (1).

(2) The Board must estimate the following deductions for the calendar year immediately preceding the injury, based on the worker's average earnings as determined under Division 7 of this Part [Part 4 of the *Act* — Compensation to Injured Workers and Their Dependants]:

(a) if premiums are payable by the worker under the *Employment Insurance Act* (Canada), those premiums;

(b) if contributions are payable by the worker under the *Canada Pension Plan*, those contributions;

(c) unless a worker is exempt from, or not subject to, the taxes imposed by the *Income Tax Act* and the *Income Tax Act* (Canada), probable income taxes payable by the worker under those Acts.

(3) In order to determine a worker's average net earnings under this section, the Board must deduct the amounts estimated under subsection (2) from the worker's average earnings as determined under Division 7 of this Part [Part 4 of the *Act* — Compensation to Injured Workers and Their Dependants].

(4) To estimate probable income taxes for the purposes of this section, the Board must assume that the following are the only deductions that may be made for a worker under the *Income Tax Act* and the *Income Tax Act* (Canada):

(a) the amounts that may be deducted under

(i) section 4.3 (1) (c) *[BC basic personal credit — single status]* of the *Income Tax Act*, and

(ii) section 118 (1) (c) *[equivalent]* of the *Income Tax Act* (Canada);

(b) the amounts that may be deducted under

(i) section 4.64 *[B.C. credit for EI premium and CPP contribution]* of the *Income Tax Act*, and

(ii) section 118.7 *[equivalent]* of the *Income Tax Act* (Canada);

(c) the amounts that may be deducted under

(i) section 4.3 (1) (a), (b) or (d.1) *[other personal credits]* of the *Income Tax Act*, and

(ii) section 118 (1) (a), (b) or (d) *[equivalent]* of the *Income Tax Act* (Canada).

Section 222:

(1) The Board may establish for each calendar year one or more schedules of deductions under section 220 [Average net earnings: short-term compensation] or 221 [Average net earnings: long-term compensation], or procedures for determining those deductions, that may be used as a guide to determining the deductions under those sections.

(2) The Board is not required to consider a worker's actual circumstances

(a) in establishing a schedule or procedure under subsection (1), or

(b) in calculating the average net earnings of the worker under this Division [Division 8 of Part 4 of the *Act* — Average Net Earnings of Worker].

POLICY

A. INTRODUCTION

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

Before calculating a worker's average net earnings, the Board determines the worker's average earnings. The process for determining a worker's average earnings is described in Items C9-65.00 – C9-70.00.

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

(a) probable EI premiums;

(b) probable CPP contributions; and

(c) probable income taxes.

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

If a worker's average earnings before the injury are less than the minimum average earnings per week established by section 191, temporary disability wage-loss benefits are not based upon 90% of average net earnings. Instead, the Board pays the worker wage-loss benefits equal in amount to the worker's loss of earnings. Consequently, there will be no deductions under Division 8 of Part 4 of the *Act* – Average Net Earnings of the Worker – from the worker's average earnings to produce average net earnings.

Under sections 220 and 221 of the *Act*, the Board calculates a worker's average net earnings at two stages in the claim process as described below.

B. SHORT-TERM AVERAGE NET EARNINGS

Under section 220 of the *Act* short-term average net earnings apply to the period set out in section 210.

Under section 210, the short-term average net earnings period begins on the date of the worker's injury and ends on the earlier of:

(a) the date wage-loss benefits have been payable to the worker for a cumulative period of 10 weeks; or

(b) the effective date of permanent disability compensation.

Schedule of Deductions

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

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

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

Probable CPP and EI

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

Probable Income Taxes

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

(a) credits based on the basic personal amounts, multiplied by 1.5; and

(b) credits for the probable CPP contributions and EI premiums payable for the worker's average earnings.

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

C. LONG-TERM AVERAGE NET EARNINGS

Under section 221 of the *Act* long-term average net earnings apply to the period commencing on the earlier of:

(a) the first day after the date wage-loss benefits have been payable to the worker for a cumulative period of 10 weeks; or

(b) the effective date of permanent disability benefits.

Formulas for Deductions

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

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

When calculating a worker's long-term average net earnings, the Board uses the formulas in effect in the calendar year preceding the date of the worker's injury.

Probable CPP and EI

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

Probable Income Taxes

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

(a) credits based on the basic personal amounts;

(b) credits for EI premiums and CPP contributions; and

(c) spousal credit or wholly dependent person credit and/or Canada caregiver credit.

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

Exceptions

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

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

D. INSUFFICIENT INFORMATION

A worker has an obligation under section 153 of the *Act* to provide the Board with the information that the Board considers necessary to administer the worker's claim. If a worker fails to comply with this obligation, the Board may reduce or suspend payments to the worker until the worker complies. The worker's obligation to provide information is discussed in Item C12-93.20.

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

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

E. ADJUSTMENTS

The Board may adjust a worker's average earnings subject to reconsideration rules set out in section 123 of the *Act*, if they were based upon incorrect information. If the adjustment results in a decrease in the value of the worker's earnings, the Board will consider Item C7-48.10 in determining whether to declare an overpayment. If it results in an increase, a retroactive adjustment may be made.

EFFECTIVE DATE:	July 4, 2025
AUTHORITY:	Sections 210, 211, 220, 221, and 222 of the *Act*.
CROSS REFERENCES:	None.
HISTORY:	December 1, 2025 − Housekeeping change to update internal cross-references, consequential to reformatting and renumbering Chapter 7, *Protection of and Deductions from Benefits* and Chapter 12, *Claims Procedures*. July 4, 2025 − This policy consolidates former policy items #71.00, #71.10, #71.20, #71.30, #71.40, of the *Rehabilitation Services & Claims Manual*, Volume II, consequential to reformatting and renumbering the policies in Chapter 9. January 1, 2024 − Reorganization of policy direction from former policy item #34.51 into this Item, consequential to the reformatting and renumbering of policies in Chapter 5, *Wage-Loss Benefits and Return to Work Obligations*. October 29, 2020 − Amended to reflect amendment to the reconsideration provisions in the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted reference to Board officer. Updated reference to Canada Revenue Agency. October 1, 2007 – Amended to include reference to then section 96(5) of the *Act* and to delete the term net.
APPLICATION:	Applies to all decisions made on or after July 4, 2025.

RE: Health Care – Introduction **ITEM: C10-72.00**

BACKGROUND

1. Explanatory Notes

This policy defines key terms and sets out general principles regarding a worker's entitlement to health care.

2. The Act

Section 1, in part:

> **"compensation"** includes health care;
>
> ...
>
> **"health care"**, when used in a compensation provision, includes things that the Board is empowered under this Act to provide for injured workers;
>
> ...
>
> **"physician"** means a medical practitioner;
>
> ...
>
> **"qualified practitioner"** means
>
> (a) a nurse practitioner, or
>
> (b) a person who is authorized under the *Health Professions and Occupations Act* to practise the designated health profession of chiropractic, dentistry, naturopathic medicine or podiatry;
>
> ...
>
> **"specialist"** means a physician who
>
> (a) resides and practises in British Columbia, and
>
> (b) is recognized as having specialist qualifications by the regulator that is responsible, under the *Health Professions and*

Occupations Act, for governing the designated health profession of medicine;

...

Section 134, in part:

(4) If an injury disables a worker from earning full wages at the work at which the worker was employed, compensation other than a health care benefit is payable under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] from the first working day following the day of the injury.

(5) A health care benefit may be provided for an injured worker in respect of the day of the injury.

Section 136, in part:

(1) Compensation is payable under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] in relation to an occupational disease, as if the disease were a personal injury arising out of and in the course of a worker's employment, if

(a) as applicable,

(i) the worker has an occupational disease that disables the worker from earning full wages at the work at which the worker was employed, or

(ii) the death of the worker is caused by an occupational disease, and

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

...

(3) A health care benefit may be provided for a worker who has an occupational disease referred to in subsection (1)(b) even though the worker is not disabled from earning full wages at the work at which the worker was employed.

Section 156:

(1) In addition to other compensation provided under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants], the Board may provide for an injured worker any services or supplies, including related transportation, that the Board considers reasonably necessary at the time of the injury and afterwards during the worker's disability to cure the injury or alleviate the effects of the injury.

(1.1) The services and supplies referred to in subsection (1) may be provided before the Board determines a worker's entitlement to compensation under this Part if the Board is satisfied that medical evidence indicates that without such services or supplies the worker is at risk of a significant deterioration in health.

(1.2) If a service or supply is provided under subsection (1.1) and the Board later determines that the worker is not eligible for compensation under this Part, the worker is not required to reimburse the Board for that service or supply.

(2) The Board may adopt rules and regulations with respect to the provision of health care to injured workers and for the payment of such health care.

(3) The Board may make a daily allowance to an injured worker for the worker's subsistence if, under the Board's direction, the worker is undergoing treatment at a place other than the place where the worker resides.

(4) The power of the Board under subsection (3) extends to an injured worker who receives compensation, regardless of the date the worker first became entitled to compensation.

Section 162:

(1) If a worker has a permanent total disability, the Board must, within the 3-month period before a retirement benefit under section 206 *[retirement benefits for workers with permanent disability]* is payable to the worker, evaluate the worker's need or continued need for services and personal supports under this Division [Division 4 of Part 4 of the *Act* – Vocational Rehabilitation, Health Care and Other Assistance].

(2) After the evaluation under subsection (1) is completed, the Board must take all actions necessary to provide to the worker, for the

worker's life, the services and personal supports under this Division that the Board considers necessary.

(3) This section does not limit the powers of the Board to otherwise provide services and personal supports to workers at any time under this Division.

POLICY

1. DEFINITIONS

In addition to the terms defined in the *Act*, the following terms, defined by the Board, are used throughout this Chapter:

"Activities of daily living" are basic activities that are performed by individuals on a daily basis for self-care. Examples include, but are not limited to: ambulating (e.g. walking), transferring (e.g. getting from bed to chair and back), feeding, dressing, personal hygiene (e.g., bathing, grooming, bladder and bowel care), and taking medication.

"Health care" may include, but is not limited to, the following:

- services provided by physicians, qualified practitioners and other recognized health care professionals;
- services provided by a health care facility;
- prescription medications;
- modifications to a person's home or vehicle;
- medical supplies, equipment, devices and prostheses;
- certain transportation and subsistence costs associated with obtaining health care; and
- additional benefits for severely disabled workers.

"Health care account" means a statement of fees owed for goods and/or services supplied, which a physician, qualified practitioner or other recognized health care professional submits to the Board (including reporting or form fees) for health care provided to a worker.

"Health care facility" means a hospital; surgical facility; office of a physician, qualified practitioner or other recognized health care professional; group home; or other place where acute, intermediate or long-term health care services or programs, are provided.

"Instrumental activities of daily living" are activities related to independent living. Examples include, but are not limited to: using a telephone, preparing meals, performing housework, shopping for groceries or personal items, managing medication, managing money, using public transportation, and maintaining and/or driving a car.

"Other recognized health care professionals" are health care professionals, other than physicians and qualified practitioners, recognized by the Board through contracts and/or fee schedules, to provide health care to injured workers, such as acupuncturists, audiologists, community health workers, denturists, dietitians, massage therapists, nurses other than nurse practitioners, occupational therapists, opticians, optometrists, pharmacists, physiotherapists, prosthetists and orthotists, psychologists, and other mental health care providers.

"Residence" means the place where a worker lives or regularly stays. Where the worker has more than one residence, the worker is required to identify one as the primary residence.

2. GENERAL PRINCIPLES

2.1 Objectives

The Board's objective is to provide reasonably necessary health care to cure or alleviate the effects of a compensable personal injury, occupational disease or mental disorder. In order to meet this objective, the Board aims to:

- facilitate the timely delivery of treatment;
- ensure that health care provided is appropriate and safe;
- ensure that injured workers receive quality care and services from physicians, qualified practitioners and other recognized health care professionals;
- work collaboratively with injured workers and their physicians, qualified practitioners and other recognized health care professionals in the development of treatment and rehabilitation plans;
- promote safe and early recovery and return to work;
- balance the individual needs of injured workers and the need to ensure the financial integrity of the workers' compensation system;
- support the long-term health care needs of severely disabled workers; and
- ensure that the health care provided is supported by up-to-date scientific evidence and information.

2.2 Duration of Entitlement to Health Care

On accepted personal injury and mental disorder claims, entitlement to health care begins on the date of injury. On accepted occupational disease claims, entitlement to health care begins on the date the worker first seeks treatment by a physician, qualified practitioner or other recognized health care professional.

Health care continues for as long as the Board considers it reasonably necessary with respect to the worker's compensable personal injury, occupational disease or mental disorder. In making this decision, the Board may consider medical opinion or other expert professional advice.

Health care may continue even if the worker is not disabled from earning full wages at the work at which they are employed, or is retired from the workforce.

Health care may be provided before the Board determines a worker's entitlement to compensation, if the Board is satisfied that medical evidence indicates that without health care, the worker is at risk of significant deterioration in health.

2.3 When a Worker Leaves British Columbia

Workers who reside in British Columbia on the date of injury and subsequently wish to leave British Columbia, either temporarily or permanently, are required to discuss the potential health care ramifications with the Board. If leaving British Columbia might impede the worker's recovery, compensation may be suspended if the circumstances set out in Item C10-74.00 are met.

The Board does not generally pay in excess of British Columbia rates for health care rendered outside British Columbia to a worker who has voluntarily left British Columbia.

2.4 When a Worker Retires

The Board assesses the health care needs of workers with permanent total disabilities during the three month period before their retirement benefits are payable.

In assessing a permanently totally disabled worker, the Board focuses on the health care benefits, services and personal supports that the worker will need or continue to need, after retirement.

EFFECTIVE DATE: October 21, 2020
AUTHORITY: Sections 1, 134, 136, 156, and 162 of the *Act*.
CROSS REFERENCES: *Rehabilitation Services & Claims Manual*, Volume II:
Item C4-26.00, *"Date of Injury" For Occupational Disease*;
Item C10-74.00, *Reduction or Suspension of Compensation*;

Item C10-75.10, *Health Care Accounts – Health Care Provided Out-of-Province*;
Chapter 18 – Retirement Benefits.

HISTORY: April 1, 2026 – Housekeeping changes to the Background section resulting from the replacement of the *Health Professions Act* with the *Health Professions and Occupations Act*.
June 1, 2024 − Housekeeping changes made to modernize terminology by removing gendered language.
October 21, 2020 – Amended to reflect amendment to the health care provisions in the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
January 1, 2015 – Policy amended to include nurse practitioners as qualified practitioners in accordance with changes to the *Act* resulting from the *Miscellaneous Statutes Amendment Act, 2014*, of 2014, Bill 17.
Policy also consolidated and replaced former policy items #72.00, #73.00, #73.01, #73.20, #73.40 and #73.54 of the *Rehabilitation Services & Claims Manual*, Volume II.

APPLICATION: Applies on or after October 21, 2020.

RE:	Direction, Supervision, and Control of Health Care	ITEM:	C10-73.00

BACKGROUND

1. Explanatory Notes

This policy sets out the Board's responsibility for the direction, supervision, and control of health care for injured workers.

2. The Act

Section 154, in part:

(1) The Board may require a worker who applies for or is receiving compensation under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] to be medically examined at a place reasonably convenient for the worker.

(2) If the worker fails to attend an examination under this section or obstructs the medical examiner,

(a) the worker's right to compensation is suspended until the examination has taken place, and

(b) no compensation is payable during the period of suspension.

...

Section 156:

See Item C10-72.00.

Section 157, in part:

(1) Health care provided under any of the following provisions must at all times be subject to the direction, supervision and control of the Board:

(a) section 156 *[Board may provide health care for injured worker]*;

(b) section 158 *[emergency care by physician or qualified professional]*;

(c) section 159 *[employer authority and obligations in relation to health care]*.

(2) All questions as to the necessity, character and sufficiency of health care to be provided are to be determined by the Board.

(3) The Board may, for any health care required,

(a) contract with physicians, nurses or other persons authorized to treat human ailments and with hospitals and other institutions, and

(b) agree on a scale of fees or remuneration for that health care.

…

Section 158:

The Board must pay the costs of services provided by a physician or qualified practitioner, other than one provided by the Board, if

(a) the physician or qualified practitioner is called in to treat an injured worker in a case of emergency or for other justifiable cause, and

(b) the Board considers there was a justifiable cause and that the charge for the services is reasonable.

Section 160:

(1) The Board must permit health care to be administered, so far as the selection of a physician or qualified practitioner is concerned, by a physician or qualified practitioner who may be selected or employed by the injured worker.

(2) Subsection (1) does not limit the powers of the Board under this Division [Division 4 of Part 4 of the *Act* – Vocational Rehabilitation, Health Care and Other Assistance] respecting the supervision and provision of health care in every case where the Board considers the exercise of those powers is expedient.

POLICY

1. GENERAL

Health care provided to injured workers is at all times subject to the direction, supervision, and control of the Board.

The Board determines all questions as to the necessity, character, and sufficiency of health care to be provided for injured workers. When making this determination, the Board may seek medical opinions or other expert professional advice to assist in determining if a given health care benefit or service is reasonably necessary.

The control of health care by the Board is not intended to exclude injured workers' choices. The Board uses its control over health care to do such things as ensure that health care options are not overlooked, promote recovery, facilitate return to work, and exclude choices by injured workers, physicians, qualified practitioners and/or other recognized health care professionals that will delay recovery, involve unnecessary or ineffective treatment, or create an unwarranted risk of further injury, increased disablement, disease or death. If there are reasonable choices of treatment, or reasonable differences of opinion among the medical profession with regard to the preferable treatment, or choices to be made that depend on personal preferences, the matter should be regarded as one of patient choice.

The Board's exercise of control relates largely to the approval or denial of health care payments, but can also include such things as directing an injured worker to be examined by a specialist or to attend a particular health care facility.

Where the Board considers health care to be reasonably necessary, and more than one type is available, the Board determines whether the choices are equally effective in terms of expected outcomes and length of disability, and are of a similar cost.

If there is a substantial difference in costs of equally effective health care options, the Board normally authorizes the option that is expected to be the least costly. In such cases, if the physician, qualified practitioner, other recognized health care professional, and/or worker chooses the more costly option, the Board pays for costs up to the amount that would have been paid for the authorized health care option.

If there is no substantial difference in costs between equally effective health care options, the choice is left to the worker.

If a worker travels outside British Columbia, and wishes to obtain health care the Board otherwise considers to be reasonably necessary, the worker should be advised that the Board will generally not pay in excess of the rates paid for medical treatment in British Columbia.

Generally, the Board does not pay for health care that is new, non-standard or not generally accepted by the Board, unless prior approval has been obtained.

2. SELECTION OF A PHYSICIAN OR QUALIFIED PRACTITIONER

Subject to the Board's overriding supervisory power, the worker may select the worker's own physician or qualified practitioner. For the purpose of sections 156, 157, 158, 159, 160, and 161 of the *Act*, there is no distinction between a physician and a qualified practitioner.

Where a worker wishes to make a change of physician or qualified practitioner, the following guidelines apply:

(a) Where a worker moves residence, a new physician or qualified practitioner may be selected in the new community without prior permission from the Board.

(b) Where a worker receives emergency treatment from a physician who is not the family physician, the worker may transfer to the family physician without prior permission from the Board.

(c) Where a worker wishes to change physician or qualified practitioner because of a loss of rapport with them, or because of a preference for a type of treatment available from a different type of physician or qualified practitioner, the change will be permitted unless the Board concludes that it is likely to be harmful, or medically unsound by reason of the circumstances relating to that particular case.

(d) Where a worker makes multiple changes of physicians or qualified practitioners and it appears to the Board that the worker is looking to find the physician or qualified practitioner whom the worker thinks is likely to provide a more favourable report, the Board may deny the change, and may not pay for treatment from the new physician or qualified practitioner. In determining whether to approve and pay for treatment from the worker's change of physician or qualified practitioner, the Board considers whether a rational treatment program is being followed.

(e) Where a worker attends walk-in clinics instead of, or in addition to, having a family physician and therefore does not see the same physician, the Board does not deny a worker's change of physician on this basis alone.

If the Board concludes that a worker's choice of physician or qualified practitioner is harmful or unsound, the decision is communicated to all physicians and qualified practitioners concerned, as well as to the worker. In these circumstances, the Board may reduce or suspend compensation if the circumstances in Item C10-74.00 are met.

Where a worker attends a physician or qualified practitioner whose right to render health care has been cancelled or suspended by the Board under the provisions referred to in Item C12-95.00, the Board will not pay for the treatment or services rendered.

3. CONCURRENT TREATMENT

Concurrent treatment occurs when a worker's treatment is overseen by more than one physician or qualified practitioner at a time.

The Board's general position is that a worker's treatment should be overseen by only one physician or qualified practitioner at a time.

There are cases, however, where the Board may consider concurrent treatment to be reasonable.

The Board may consider concurrent treatment reasonable in situations such as when a worker's disability requires treatment by a physician and a specialist, by two or more specialists, or by a qualified practitioner with concurrent monitoring by a physician. The Board may also consider concurrent treatment reasonable when a worker is transitioning from one form of treatment to another. In this instance, the Board may determine that it is warranted for the treatments to overlap for a limited time.

The Board does not refuse concurrent treatment simply because it is inconsistent with a rule or policy of a professional organization.

4. AUTHORIZATION OF ELECTIVE SURGERY

Elective surgery is considered optional or not urgently necessary surgical treatment.

The Board does not expect physicians or qualified practitioners working under emergency conditions to obtain prior authorization from the Board before performing necessary surgical treatments. However, the Board does not generally pay for any elective surgical treatments unless prior authorization from the Board has been obtained.

The Board determines whether to authorize elective surgery based on the applicable medical evidence. The Board may refuse to authorize an elective surgical treatment if the Board considers it to be:

- unduly hazardous, having regard to its potential benefits and the risks involved in not having the surgery;
- unlikely to promote recovery;
- unnecessary; or

- reasonable to try less invasive measures first.

Before the Board refuses authorization of an elective surgical treatment, the Board normally discusses this decision with the worker's physician or qualified practitioner. The Board notifies the worker and the worker's physician or qualified practitioner of its decision.

If the worker decides to proceed with the unauthorized elective surgical treatment, the Board does not pay for the treatment or any expenses associated with recovery from that treatment. As well, the Board may consider the worker to have engaged in an unsanitary or injurious practice, and may reduce or suspend the worker's compensation, if the circumstances in Item C10-74.00 are met.

5. EXAMINATIONS

An injured worker's physician, qualified practitioner or other recognized health care professional may request that the Board conduct a medical examination of the injured worker. Similarly, the Board may direct an injured worker to submit to a medical examination.

A "medical examination" is not limited to examinations performed by physicians. It also includes examinations by qualified practitioners and other recognized health care professionals. The term "examination" may include a consultation (e.g. with a dentist), or an assessment (e.g. by a psychologist).

A Board-directed medical examination may be conducted by the worker's own physician, the Board or an external physician, qualified practitioner or other recognized health care professional, as determined by the Board.

In all cases, the Board notifies the injured worker in advance of the type of physician, qualified practitioner or other recognized health care professional who will conduct the examination. The Board also notifies the injured worker's physician, qualified practitioner, or other recognized health care professional of its intention to proceed with a Board-directed medical examination.

Following a Board-directed medical examination, the Board notifies the worker's physician, qualified practitioner or other recognized health care professional of those medical matters that should be brought to their attention following the examination.

EFFECTIVE DATE: January 1, 2024
AUTHORITY: Sections 1, 154, 156, 157, 158, and 160 of the *Act.*

CROSS REFERENCES:

Item C3-22.00, *Compensable Consequences*;
Item C10-74.00, *Reduction or Suspension of Compensation*;
Item C10-75.00, *Health Care Accounts – General*;
Item C10-76.00, *Physicians and Qualified Practitioners*;
Item C10-77.00, *Other Recognized Health Care Professionals*;
Item C10-79.00, *Health Care Supplies and Equipment*;
Item C10-84.00, *Additional Benefits for Severely Disabled Workers*;
Item C12-95.00, *Responsibilities of Physicians and Qualified Practitioners*;
Item C12-97.30, *Medical Evidence*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:

December 1, 2025 − Housekeeping change to update internal cross-reference, consequential to reformatting and renumbering Chapter 12, *Claims Procedures*.
June 1, 2024 − Housekeeping changes made to modernize terminology by removing gendered language.
January 1, 2024 − Reorganization of policy direction from former policy item #34.51 into this Item, consequential to the reformatting and renumbering of policies in Chapter 5, *Wage-Loss Benefits and Return to Work Obligations*.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
January 1, 2015 − This policy consolidated and replaced former policy items #74.23, #74.25, #74.50, #74.60, #78.00, #78.10, #78.11, #78.20 and #78.21 of the *Rehabilitation Services & Claims Manual,* Volume II.
June 1, 2009 – deleted references to Board officer, Board Medical Advisors, Medical Advisor, and Medical Advisor/Consultant.

APPLICATION:

Applies to all decisions made on or after January 1, 2024.

RE: Reduction or Suspension of Compensation **ITEM: C10-74.00**

BACKGROUND

1. Explanatory Notes

This policy outlines the circumstances in which the Board may suspend a worker's compensation for failing to attend an examination or obstructing a medical examiner, and reduce or suspend a worker's compensation for refusing to submit to medical or surgical treatment or persisting in unsanitary or injurious practices.

2. The Act

Section 1, in part:

> **"compensation"** includes health care;
>
> ...
>
> **"health care"**, when used in a compensation provision, includes things that the Board is empowered under this Act to provide for injured workers;
>
> ...

Section 154:

> (1) The Board may require a worker who applies for or is receiving compensation under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] to be medically examined at a place reasonably convenient for the worker.
>
> (2) If a worker fails to attend an examination under this section or obstructs the medical examiner,
>
> (a) the worker's right to compensation is suspended until the examination has taken place, and
>
> (b) no compensation is payable during the period of suspension.

(3) The Board may reduce or suspend compensation for a worker if the worker

(a) persists in unsanitary or injurious practices that tend to imperil or delay the worker's recovery, or

(b) refuses to submit to medical or surgical treatment that the Board considers, based on expert medical or surgical advice, reasonably essential to promote the worker's recovery.

POLICY

1. GENERAL

Where certain prerequisites are satisfied, the Board may reduce or suspend a worker's compensation. The situations where this may occur are discussed in more detail in the sections that follow.

The reduction or suspension of compensation commences as of the date of the Board's decision. This includes the reduction or suspension of health care on the claim, as the definition of "compensation" in the *Act* includes health care.

The reduction or suspension of compensation is limited to the claim at issue and does not apply to any compensation the worker may be receiving under other claims.

1.1 Reasonable Explanation

Prior to reducing or suspending compensation, the Board gives a worker an opportunity to provide an explanation for the worker's conduct. If the Board considers there is a reasonable explanation, compensation is not reduced or suspended. Reasonable explanations include, but are not limited to:

- unexpected illness;
- compelling personal reasons, such as a death in the family; or
- unexpected transportation difficulty where a reasonable attempt was made to overcome the difficulty, such as by using an alternate mode of transportation.

If the Board does not consider there to be a reasonable explanation for the worker's conduct, or if an explanation is not forthcoming, the Board may proceed to reduce or suspend compensation.

1.2 Reinstatement of Compensation

Generally, when compensation is reinstated following a period of reduction or suspension, it is reinstated prospectively from the date of the Board's decision to reinstate. If the Board's decision to reduce or suspend compensation includes the reduction or suspension of the worker's right to health care, the Board does not pay health care accounts that are incurred during the period of the reduction or suspension.

If the worker provides a reasonable explanation for the conduct that resulted in the reduction or suspension, the Board may reinstate the compensation retroactively to the date it was reduced or suspended. In this case, the Board may pay any outstanding health care accounts incurred during the period of the reduction or suspension.

If a worker's temporary disability stabilizes as a permanent impairment while compensation is reduced or suspended, the effective date of the resulting permanent disability benefit is the date on which the worker's temporary disability stabilized as a permanent impairment, not the day following the date of reduction or suspension of compensation.

2. FAILURE TO ATTEND OR OBSTRUCTION OF A MEDICAL EXAMINATION

Section 154(2) of the *Act* suspends a worker's right to compensation on a claim if the worker fails to attend an examination or obstructs a medical examiner. The worker's right to compensation on the claim is suspended until the examination that the worker failed to attend or obstructed has taken place and been effectively completed.

In applying this section of the *Act*, the Board does not limit the terms "medical examination" to examinations performed by physicians or "medical examiner" to physicians. It also includes examinations by qualified practitioners and other recognized health care professionals. The term "examination" may include a consultation (e.g. with a dentist), or an assessment (e.g. by a psychologist).

In determining whether a worker has failed to attend a medical examination, the Board considers whether the worker:

- has received notice of the date, time and place of the appointment;
- did not attend; and
- did not give adequate notice that they would not be attending.

In determining whether a worker has obstructed a medical examiner, the Board considers whether the worker behaved in a manner that prevented the examination from being effectively completed.

Before the Board suspends a worker's compensation for failing to attend an examination or obstructing a medical examiner, the Board takes the following actions:

(a) The Board determines whether the worker has failed to attend an examination or has obstructed a medical examiner.

(b) If the Board determines the worker has failed to attend an examination or has obstructed a medical examiner, the Board then advises the worker that all compensation on the claim will be suspended if the examination is not effectively completed and attempts to reschedule the examination.

(c) If the worker fails to reschedule or continues to avoid or obstruct the examination, the Board gives the worker an opportunity to provide an explanation for the worker's conduct.

(d) If the Board does not consider the worker's explanation to be reasonable, the Board suspends the worker's compensation on the claim.

When the Board notifies the worker of its decision to suspend compensation under section 154(2) of the *Act*, the Board includes notice of a further appointment for the examination, and advises that, if the worker attends and allows the examination to be effectively completed, compensation will be reinstated.

3. PERSISTING IN UNSANITARY OR INJURIOUS PRACTICES

The Board has discretion under section 154(3)(a) of the *Act* to determine whether and how a worker's compensation may be affected by the worker's persistence in unsanitary or injurious practices that tend to imperil or delay the worker's recovery. The Board may reduce the worker's compensation, suspend the worker's compensation or continue with the worker's compensation.

If the Board chooses to reduce the worker's compensation, the Board has the further discretion to determine whether the reduction of the compensation means suspending the health care on that claim or just suspending the wage-loss benefits or permanent disability benefits payment on that claim.

Before the Board reduces or suspends a worker's compensation for persisting in unsanitary or injurious practices, the Board takes the following actions:

(a) The Board determines whether the worker is engaging in an unsanitary or injurious practice that tends to imperil or delay the worker's recovery, taking medical opinion or other expert professional advice into consideration as necessary.

(b) If the Board determines the worker is engaging in an unsanitary or injurious practice, the Board then advises the worker that the practice may inhibit recovery or lead to further injury and must be discontinued, otherwise some or all of the compensation on the claim may be reduced or suspended.

(c) If the worker persists in the unsanitary or injurious practice, the Board gives the worker an opportunity to provide an explanation for the worker's conduct.

(d) If the Board does not consider the worker's explanation to be reasonable, the Board determines whether to reduce the worker's compensation on the claim (e.g. suspend wage-loss benefits or permanent disability benefits, but not health care) or suspend all of the worker's compensation on the claim (including health care).

If the Board reduces or suspends the worker's compensation on the claim under section 154(3)(a) of the *Act*, the worker must satisfy the Board that the unsanitary or injurious practice has ceased and will not be repeated, before the Board reinstates full compensation.

Compensation may be terminated on other grounds if the unsanitary or injurious practice a worker is engaged in shows that the worker was not disabled during the period in question, or if the evidence indicates that the worker's disability is due to the unsanitary or injurious practice rather than to the original compensable personal injury, occupational disease or mental disorder.

4. REFUSAL TO SUBMIT TO MEDICAL OR SURGICAL TREATMENT

The Board has discretion under section 154(3)(b) of the *Act* to reduce or suspend a worker's compensation if the worker refuses to submit to medical or surgical treatment that the Board considers, based on expert medical or surgical opinion, or other expert professional advice, is reasonably essential to promote the worker's recovery.

If the Board chooses to reduce or suspend the worker's compensation, the Board has the further discretion to determine whether the reduction or suspension of the compensation applies to the health care on that claim and/or the wage-loss benefits or permanent disability benefits on that claim.

In applying this section of the *Act*, the Board does not limit the phrase "medical or surgical treatment" to treatment performed by physicians. It also includes treatment provided by qualified practitioners and other recognized health care professionals that the Board considers, based on medical opinion or other expert professional advice, reasonably essential to promote the worker's recovery.

Before the Board reduces or suspends a worker's compensation for refusing to submit to treatment, the Board takes the following actions:

(a) The Board determines whether the worker is refusing to submit to treatment.

(b) If the Board determines the worker is refusing to submit to treatment, the Board obtains a medical opinion or other expert professional advice that the treatment in question is reasonably essential to promote the worker's recovery.

(c) If the Board determines the worker is refusing to submit to treatment that, based on medical opinion or other expert professional advice, is reasonably essential to promote the worker's recovery, the Board then:

- advises the worker of this decision and that some or all of the compensation on the claim may be reduced or suspended if the worker does not submit to the treatment; and
- gives the worker an opportunity to provide an explanation for the worker's conduct.

(d) If the Board does not consider the worker's explanation to be reasonable, the Board determines whether to reduce the worker's compensation on the claim (e.g. suspend wage-loss benefits or permanent disability benefits payments, but not health care) or suspend all of the worker's compensation on the claim (including health care).

If the Board reduces or suspends the worker's compensation on the claim under section 154(3)(b) of the *Act*, the worker must submit to the Board-approved medical or surgical treatment, before the Board reinstates compensation.

EFFECTIVE DATE: January 1, 2015
AUTHORITY: Sections 1 and 154 of the *Act*.
CROSS REFERENCES: Item C5-34.00, *Duration of Wage-Loss Benefits*;
Item C10-72.00, *Health Care – Introduction*;
Item C10-73.00, *Direction, Supervision, and Control of Health Care*;
Item C10-75.00, *Health Care Accounts – General*;
Item C12-93.00, *Responsibilities of Claimants*;
Item C12-93.20, *Obligation to Provide Information*;
Item C14-102.01, *Changing Previous Decisions – Reopenings*;
Item C14-104.01, *Changing Previous Decisions – Fraud and Misrepresentation*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:

June 1, 2024 − Housekeeping changes made to modernize terminology by removing gendered language.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
January 1, 2015 − This policy incorporated concepts from former policy item #73.30, and consolidated and replaced former policy items #78.12, #78.13, and #78.24 of the *Rehabilitation Services & Claims Manual*, Volume II.
June 1, 2009 – Deleted references to Board officer and Medical Advisor from former policy items.

APPLICATION:

This Item applies on or after January 1, 2015.

RE: Health Care Accounts – General **ITEM: C10-75.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the manner in which the Board administers health care accounts.

2. The Act

Section 156:

> See Item C10-72.00.

Section 157:

> See Item C10-73.00.

Section 164(6):

> Unless the Board otherwise directs, an account for medical services or other health care must not be paid if it is submitted later than 90 days after the date of whichever of the following occurs first:
>
> (a) the last treatment was given;
>
> (b) the person providing the health care was first aware that the Board may be liable for that person's services.

POLICY

1. DEFINITIONS

As set out in Item C10-72.00, "health care account" means a statement of fees owed for goods and/or services supplied, which a physician, qualified practitioner or other recognized health care professional submits to the Board (including reporting or form fees) for health care provided to a worker.

"Reporting or form fees" means fees in relation to reports or forms that physicians, qualified practitioners or other recognized health care professionals submit to the Board.

2. SUBMISSION OF HEALTH CARE ACCOUNTS

The Board audits all health care accounts submitted to ensure compliance with the *Act*, any applicable contracts and fee schedules, and to ensure that the health care provided is appropriate given the worker's compensable disability.

The Board may be in receipt of health care accounts that the Board does not pay for a number of reasons. Such reasons may include, but are not limited to the following:

- the health care provided to a worker is not related to the worker's compensable personal injury, occupational disease or mental disorder;
- the Board does not consider the health care provided to a worker to be reasonably necessary to treat the compensable personal injury, occupational disease or mental disorder;
- the Board has determined that the worker's compensable personal injury, occupational disease or mental disorder has resolved;
- the Board considers the report in support of the health care account inadequate; or
- a previous decision to allow the worker's claim for personal injury, occupational disease or mental disorder is reversed on reconsideration, review or appeal.

If the Board is in receipt of a health care account that the Board will not pay, the Board notifies the physician, qualified practitioner or other recognized health care professional who submitted the health care account as soon as possible.

As required by the *Act*, the physician, qualified practitioner or other recognized health care professional must submit health care accounts promptly after health care is provided. Where a health care account is not submitted promptly and the delay hinders the Board's decision-making ability, the Board may not pay the health care account.

3. AMOUNTS PAYABLE

The amounts the Board pays to physicians, qualified practitioners or other recognized health care professionals are generally governed by contracts and/or fee schedules, which the Board may specifically negotiate or may adopt from another agency. If there is no contract and/or fee schedule in place with respect to certain health care, the Board pays an amount for that health care that it considers reasonable.

Where the Board considers certain health care to be reasonably necessary, and more than one type is appropriate and available, but there is a substantial difference in costs, the Board normally only authorizes and pays for costs up to the amount that would have been paid for the less expensive but equally effective option.

Physicians, qualified practitioners and other recognized health care professionals are not permitted to bill a worker for any amount in excess of the amount payable by the Board. If they do so and the worker pays, the Board reimburses the worker for the excess amount and may recover that amount by deducting it from future health care accounts that the physician, qualified practitioner or other recognized health care professional submits to the Board. It is recommended, however, that workers contact the Board for information on the amount payable by the Board before obtaining non-emergency health care.

A physician, qualified practitioner or other recognized health care professional may choose to see a worker in a health care facility other than their own office. In such cases, the Board only pays for the services of the physician, qualified practitioner or other recognized health care professional and does not pay any additional fees for use of the health care facility. This would apply, for example, if a physician chooses to see a worker at a hospital rather than their office.

4. ADMINISTRATION OF HEALTH CARE ACCOUNTS

4.1 Before Initial Claims Adjudication

Generally, the Board only pays health care accounts after the worker's claim for personal injury, occupational disease or mental disorder is allowed. However, the Board may pay health care accounts submitted before a claim is initially adjudicated where:

- the health care provided is emergency health care necessary to optimize recovery (e.g. emergency surgery);
- the health care provided is necessary to assist in the adjudicative process. This includes reporting or form fees, and fees for any Board-directed examination, consultation or assessment undertaken on an investigative basis; or
- the Board is satisfied that medical evidence indicates that without health care the worker is at risk of a significant deterioration in health.

Unless pre-authorized, the Board does not generally pay health care accounts in respect of investigative surgery because such invasive procedures could result in a disability. If a worker chooses to pay for and undergo investigative surgery, the Board may consider any resultant reports in adjudicating the worker's claim. If the claim is

subsequently allowed, the Board may then pay the health care account for the investigative surgery.

If a worker's claim for personal injury, occupational disease or mental disorder is not allowed, the Board does not pay wage-loss benefits for the period prior to the date of the decision, even though the Board may have paid for certain health care expenses during that period.

4.2 Allowed Claims

4.2.1 General

When a claim for personal injury, occupational disease or mental disorder is allowed on initial adjudication, reconsideration, review or appeal, the Board does not solicit health care accounts for health care provided before the date of the decision to allow the claim. However, if the Board receives such health care accounts, and the decision allowing the claim does not deal with the question of entitlement to the health care at issue, the Board administers the health care accounts as if the claim had been allowed as of the date of injury.

The Board may reimburse a worker where the worker has received and paid for health care in good faith and on the advice of a physician, qualified practitioner or other recognized health care professional, even though the health care might not ordinarily be approved for the worker's compensable personal injury, occupational disease or mental disorder.

4.2.2 Compensable Disability Resolved

Generally, the Board does not pay health care accounts for health care provided after the date of the Board's decision that the compensable disability has resolved, unless the health care accounts are submitted promptly and in good faith in respect of reporting or form fees, or Board-directed examinations, consultations or assessments.

4.2.3 Entitlement to Treatment Limited

After a worker's claim is allowed, the Board may decide to limit a worker's entitlement to a particular type of treatment, even though the worker continues to have a compensable disability. The Board may decide to limit treatment in a number of situations. Such situations include, but are not limited to, the following:

- preventing the provision of concurrent treatment; or
- denying the extension of a particular type of treatment.

Generally, the Board does not pay health care accounts for health care provided after the date of the Board's decision to limit a worker's entitlement to a particular type of

treatment, unless the health care accounts are submitted promptly and in good faith in respect of treatment provided on or before the decision date.

4.3 Disallowed or Rejected Claims

A decision to disallow or reject a worker's claim for personal injury, occupational disease or mental disorder may be made on initial adjudication, reconsideration, review or appeal. Generally, the Board does not pay health care accounts for health care provided after the date such a decision is made, unless they are submitted promptly and in good faith in respect of reporting or form fees, or Board-directed examinations, consultations or assessments.

When a worker's previously allowed claim for personal injury, occupational disease or mental disorder is subsequently disallowed or rejected, the Board does not initiate any steps to recover amounts the Board has already paid for health care. However, if the Board were offered reimbursement by any other agency, the offer would be accepted.

EFFECTIVE DATE:	October 21, 2020
AUTHORITY:	Sections 156, 157, and 164 of the *Act*.
CROSS REFERENCES:	Item C10-73.00, *Direction, Supervision, and Control of Health Care*; Item C10-74.00, *Reduction or Suspension of Compensation*; Item C10-76.00, *Physicians and Qualified Practitioners*; Item C10-77.00, *Other Recognized Health Care Professionals*; Item C12-95.00, *Responsibilities of Physicians and Qualified Practitioners*; Item C12-96.10, *Preliminary Determinations*; Item C12-99.20, *Notification of Decisions*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	June 1, 2024 − Housekeeping changes made to modernize terminology by removing gendered language. October 21, 2020 − Amended to reflect amendment to the health care provisions in the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. January 1, 2015 − This policy consolidated and replaced former policy items #73.10, #76.20, #78.30, #78.31, #78.32, and incorporated concepts from former policy item #78.33, all of the *Rehabilitation Services & Claims Manual*, Volume II. June 1, 2009 – Deleted references to Board officer and Health Care Services Department. March 3, 2003 – Inserted references to Review Division, and Workers' Compensation Appeal Tribunal.
APPLICATION:	Applies on or after October 21, 2020.

RE: Health Care Accounts – Health Care Provided Out-of-Province **ITEM: C10-75.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the manner in which the Board administers health care accounts in respect of health care provided outside of British Columbia.

2. The Act

Section 147:

(1) This section applies if

(a) a worker is injured while working outside British Columbia, and

(b) the injury would entitle the worker or the worker's dependants to compensation under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] if the injury occurred in British Columbia.

(2) The Board must pay compensation under this Part only if all of the following apply:

(a) a place of business of the worker's employer is located in British Columbia;

(b) the worker's residence and usual place of employment are located in British Columbia;

(c) the employment is such that the worker is required to work both in and outside British Columbia;

(d) the worker's employment outside British Columbia

(i) has immediately followed the worker's employment in British Columbia by the same employer, and

(ii) has lasted less than 6 months.

Section 153:

(1) A worker who applies for or is receiving compensation under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] must provide the Board with the information that the Board considers necessary to administer the worker's claim.

(2) If a worker fails to comply with subsection (1), the Board may reduce or suspend payments to the worker until the worker complies.

Section 156:

See Item C10-72.00.

Section 157:

See Item C10-73.00.

Section 335:

(1) The Board may enter into agreements or make arrangements with Canada, a province or a territory, or with the appropriate authority of Canada, a province or a territory respecting the following:

(a) administrative cooperation and assistance between jurisdictions in all matters under this Act and corresponding legislation in other jurisdictions;

(b) the provision of compensation, rehabilitation and health care to workers in accordance with the standards established under this Act or corresponding legislation in other jurisdictions;

(c) avoidance of duplication of assessments on workers' earnings.

(2) An agreement or arrangement under this section may

(a) waive or modify a residence or exposure requirement for eligibility for compensation, rehabilitation or health care, or

(b) provide for payment to an appropriate authority of Canada or an appropriate authority of a province or a territory for compensation, rehabilitation costs or health care costs paid by the authority.

POLICY

1. DEFINITION

"Non-resident worker" is an individual who is a "worker" under the *Act*, who either resides outside British Columbia on the date of injury, or moves outside British Columbia after the date of injury.

2. GENERAL

The Board expects workers to obtain health care in British Columbia for their compensable personal injuries, occupational diseases or mental disorders. However, the Board may consider that it is reasonably necessary for a worker to obtain health care in another jurisdiction.

2.1 Emergency Health Care

For workers whose employment takes them to other provinces or territories within Canada, the Board pays emergency health care accounts received from within Canada at the rates governed by inter-provincial fee schedules, which the Board establishes under section 335 of the *Act*.

The Board generally pays any out-of-country emergency health care accounts received at the rate established in the other jurisdiction, unless that rate is higher than the British Columbia rate. In these situations, the Board may negotiate a specific rate for the health care with the other jurisdiction.

Since emergency health care cannot be scheduled in advance, prior authorization from the Board is not required.

2.2 Non-Emergency Health Care

The Board should be notified before a worker obtains out-of-province non-emergency health care in order to ensure that the Board will pay for the health care. The Board may consider out-of-province non-emergency health care appropriate where:

- it is not reasonably available or not offered in British Columbia;
- it is medically appropriate (e.g. the worker's health could be put at risk by traveling a longer distance or waiting to return to British Columbia);

- the Board has entered into a service agreement with an out-of-province agency, and there is evidence that there will be reduced claim costs due to lower travel expenses and/or an earlier return to work; or

- the worker is a non-resident worker.

If the out-of-province non-emergency health care is obtained without prior approval from the Board, the Board may not pay for it if the Board determines that the health care was not an accepted part of the claim.

The Board generally pays any out-of-province non-emergency health care accounts received at the rate established in the other jurisdiction, unless that rate is higher than the British Columbia rate. In these situations, the Board may negotiate a specific rate for the health care with the other jurisdiction.

If a worker injured near the provincial border bypasses adequate health care in British Columbia and, by personal choice, elects to receive health care outside British Columbia, the Board does not normally pay in excess of British Columbia rates for that health care.

3. REPORTS, FORMS AND OTHER INFORMATION

A worker who receives health care outside British Columbia is responsible for ensuring the Board receives all health care reports, forms, receipts and any other requested information with respect to the worker's claim from the out-of-province health care provider.

The Board may reduce or suspend payments to a worker if the worker fails to provide the Board with the information that the Board considers necessary to administer the worker's claim. The Board may also reduce or suspend compensation where the circumstances set out in Item C10-74.00 are met.

EFFECTIVE DATE:	January 1, 2015
AUTHORITY:	Sections 147, 153, 156, 157, and 335 of the *Act*.
CROSS REFERENCES:	Item C10-74.00, *Reduction or Suspension of Compensation*; Item C10-76.00, *Physicians and Qualified Practitioners*; Item C10-77.00, *Other Recognized Health Care Professionals*; Item C12-93.20, *Obligation to Provide Information*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. January 1, 2015 − This policy incorporated the concepts from and replaced former policy items #73.50, #73.51, #73.52, #73.53, and #78.33 of the *Rehabilitation Services & Claims Manual*, Volume II.
APPLICATION:	This Item applies on or after January 1, 2015.

RE: Physicians and Qualified Practitioners **ITEM: C10-76.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance regarding an injured worker's entitlement to the services of a physician or qualified practitioner.

2. The Act

Section 1, in part:

> **"physician"** means a medical practitioner;
>
> ...
>
> **"qualified practitioner"** means
>
> (a) a nurse practitioner, or
>
> (b) a person who is authorized under the *Health Professions and Occupations Act* to practise the designated health profession of chiropractic, dentistry, naturopathic medicine or podiatry;
>
> ...
>
> **"specialist"** means a physician who
>
> (a) resides and practises in British Columbia, and
>
> (b) is recognized as having specialist qualifications by the regulator that is responsible, under the *Health Professions and Occupations Act*, for governing the designated health profession of medicine;
>
> ...

Section 156:

> See Item C10-72.00.

Section 157:

See Item C10-73.00.

Section 158:

See Item C10-73.00.

Section 160:

See Item C10-73.00.

Section 161(1), in part:

The Board may assume the responsibility of replacement and repair of the following for a worker:

…

(b) eyeglasses, dentures and hearing aids broken as a result of an accident arising out of and in the course of the worker's employment …

Section 163, in part:

(1) A physician or qualified practitioner attending or consulted on a case of injury to a worker in an industry within the scope of the compensation provisions, or of an alleged case of such an injury, has the following duties:

...

(d) without charge to the worker, to give to the worker and the worker's dependants all reasonable and necessary information, advice and assistance they need to

(i) make an application for compensation, and

(ii) provide the certificates and proofs required in relation to the application.

(2) Every physician or qualified practitioner authorized under this Act to treat an injured worker is subject to the duties and responsibilities established by subsection (1), and any health care provided by the physician or qualified practitioner is subject to the direction, supervision and control of the Board.

Section 164, in part:

(1) Physicians, qualified practitioners or other persons authorized to provide health care under the compensation provisions must confine their treatment to injuries that are injuries to the parts of the body that they are authorized to treat under the Act under which they are permitted to practise.

(2) A person referred to in subsection (1) who gives treatment that is not authorized as referred to in that subsection commits an offence.

(3) A person referred to in subsection (1) who fails to submit prompt, adequate and accurate reports and accounts as required by this Act or by the Board commits an offence.

(4) If a person fails to submit reports and accounts as referred to in subsection (3), the Board may

(a) cancel the right of the person to be selected by a worker to provide health care, or

(b) suspend the person for a period determined by the Board.

(5) If the right of a person to provide health care is cancelled or suspended under subsection (4),

(a) the Board must

(i) notify the person of the cancellation or suspension, and

(ii) inform the applicable regulator under the *Health Professions and Occupations Act*, and

(b) the person must notify injured workers who seek treatment from that person of the cancellation or suspension.

...

3. Health Professions and Occupations Act

Section 25, in part:

(1) The minister may, by regulation, designate a health profession as a designated health profession.

(2) A designation regulation made under this section must include regulations respecting all of the following:

(a) the name of the regulatory college that is responsible for governing the designated health profession;

(b) the titles that licensees practising the designated health profession may use exclusively;

(c) the types of health services that constitute the scope of practice of the designated health profession.

...

POLICY

1. ENTITLEMENT TO HEALTH CARE SERVICES

An injured worker is entitled to the services of a physician and/or qualified practitioner as defined under the *Act*.

The Board establishes the types of treatment and fees it pays for health care and related services through contracts, or by implementation of fee schedules, as appropriate. If there is no contract or fee schedule in place at the time of service delivery with respect to a certain type of health care, the Board pays an amount for that health care that it considers reasonable.

Unless prior approval has been obtained, the Board does not generally pay for health care that is new or that it does not generally accept as reasonably necessary for the treatment of a compensable personal injury, occupational disease or mental disorder, or as preventative health care. The Board considers the scientific evidence and information regarding the effectiveness of such health care, as part of determining whether to grant approval.

Generally, the Board only pays health care accounts for treatment provided to injured workers at their residence, when the injured worker is non-ambulatory and the visit is pre-approved by the Board.

2. GENERAL POSITION OF PHYSICIANS AND QUALIFIED PRACTITIONERS

The Board's general position is that a worker's treatment should be overseen by only one physician or qualified practitioner at a time. There are cases, however, where the Board may consider concurrent treatment to be reasonable, as discussed in Item C10-73.00.

Physicians and qualified practitioners are confined to treat injuries that are injuries to the parts of the body that they are authorized to treat by their governing Acts, regulations and bylaws.

The Board may further limit the injuries and parts of the body they are authorized to treat. A physician or qualified practitioner who gives treatment that is not authorized by their governing Act commits an offence. The maximum fine for committing this offence is set out in Appendix 5 to this *Manual*.

The Board does not pay for a worker to attend a physician or qualified practitioner whose right to provide health care has been cancelled or suspended either by the licensing body, or by the Board under the provisions referred to in Item C12-95.00.

Physicians and qualified practitioners are required to submit prompt, adequate and accurate reports to the Board. These reports should include information on the diagnosis, the treatment possibilities, whether the injury, occupational disease or mental disorder could have been caused by the worker's employment, the worker's prognosis, and, where appropriate, expectations for return to work. Physicians and qualified practitioners are also required to give to the worker and the worker's dependants all reasonable and necessary information, including advice and assistance they need to make an application for compensation, and to provide the certificates and proofs required in relation to the application.

3. CONSULTATION WITH SPECIALIST PHYSICIANS

On an accepted claim where health care is continuing, it is not necessary for a worker to obtain approval from the Board before seeing a specialist for a consultation, provided the necessity for consultation is shown on the referring physician's reports.

Where the Board arranges a referral with a specialist, the Board notifies the worker's physician or qualified practitioner.

When either the Board or the worker's physician refers a worker to a specialist and the specialist produces a report, the specialist is required to provide a copy of the report to both the Board and the worker's physician or qualified practitioner.

3.1 Surgical Treatment

Surgeons are one type of physician recognized by the Royal College of Physicians and Surgeons of Canada as having specialist qualifications.

The Board does not expect specialist physicians working under emergency conditions to obtain prior authorization from the Board before performing necessary surgical treatments.

However, prior authorization from the Board is required before a worker receives any elective surgical treatments, including investigative surgery, and the Board applies the policy in Item C10-73.00, in making this determination. If prior authorization is not obtained and the Board determines that the elective surgical treatment was not acceptable under the claim, the Board does not pay for the treatment.

The Board does not generally authorize investigative surgery before a claim is adjudicated, because such invasive procedures could result in a disability. However, if a worker pays the cost of investigative surgery, the Board may consider any resultant reports in adjudicating the worker's claim. If the claim is subsequently allowed, the Board may then pay the health care account for the investigative surgery under Item C10-75.00.

3.2 Psychiatric Consultation and Treatment

A psychiatrist is one type of specialist physician. "Psychiatrist" means a physician who is authorized to practise in the speciality of psychiatry by the regulator that is responsible, under the *Health Professions and Occupations Act,* for governing the designated health profession of medicine, or an accredited body recognized by the Board.

The Board generally approves psychiatric examination of a worker for the purposes of assessment or consultation on an investigative basis.

Prior to paying for psychiatric treatment, the Board requires an examination report from the worker's psychiatrist relating to diagnosis, etiology, treatment possibilities and prognosis.

4. CHIROPRACTORS

Licensees in good standing with the applicable regulator responsible for governing chiropractors may provide chiropractic treatment and services to injured workers. Chiropractors may provide the chiropractic treatment and services authorized by the *Health Professions and Occupations Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

4.1 Duration of Treatment

The Board determines the duration of chiropractic treatment and services that it considers reasonable. The Board considers up to five weeks of chiropractic treatment reasonable for most compensable personal injuries, but pays for up to eight weeks of treatment.

The Board may pay for extensions beyond eight weeks based on a review of the evidence. The Board does not pay for more than one chiropractic treatment per day.

4.2 Scope of Treatment

The Board may set out the types of chiropractic treatment and services that it considers reasonable for most compensable personal injuries. The Board limits chiropractic treatment to the compensable area of injury and requires the chiropractic treatment to be reasonably necessary for the worker's compensable personal injury.

Prior to refusing or terminating authorization for chiropractic treatment, the Board considers all relevant medical opinions or other expert professional advice and information regarding the appropriateness of the treatment.

If the Board limits a worker's health care by terminating its authorization for chiropractic treatment, the Board communicates the decision to the chiropractor and the worker. The Board normally pays accounts for health care provided before the decision date.

4.3 X-rays

X-rays of the affected anatomical area may be taken for the purpose of assisting a chiropractor in the treatment of a worker. The Board pays health care accounts for x-rays in accordance with the current Board contract and/or fee schedule in place at the time of service delivery. The Board does not pay for:

- full-length views of the spine;
- x-rays of non-interpretable quality;
- x-rays of areas of the body not injured; and
- excess, or duplication of, x-rays.

5. DENTISTS

Licensees in good standing with the applicable regulator responsible for governing dentists may provide dental treatment and services to injured workers. Dentists may provide the dental treatment and services authorized by the *Health Professions and Occupations Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

The Board generally pays for dental repair for damage caused by a compensable personal injury or occupational disease. "Personal injury" includes damage to dental crowns and fixed bridgework, as they are regarded as part of the anatomy. The Board pays for repair of dentures as set out in section 161(1)(b) of the *Act* and Item C3-23.20.

Except in emergency cases, the Board does not pay health care accounts for dental treatments without prior Board approval of the dentist's proposed treatment.

Where there are two equally effective treatment plans, the Board normally authorizes the plan that is expected to be the least costly in the long term. If the dentist and/or a worker chooses the more costly option, the Board pays for costs up to the amount that would have been paid for the authorized dental treatment plan.

6. PODIATRISTS

Licensees in good standing with the applicable regulator responsible for governing podiatrists may provide podiatric treatment and services to injured workers. Podiatrists may provide the podiatric treatment and services authorized by the *Health Professions and Occupations Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

The Board determines the podiatric services that it considers reasonable. The Board may pay for podiatric services such as: primary care services, referral services, and special podiatric procedures.

7. NATUROPATHIC PHYSICIANS

Licensees in good standing with the applicable regulator responsible for governing naturopathic physicians may provide naturopathic treatment and services to injured workers. Naturopathic physicians may provide the naturopathic treatment and services authorized by the *Health Professions and Occupations Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

7.1 Duration of Treatment

The Board determines the duration of naturopathic treatment and services that it considers reasonable. The Board considers up to eight weeks of naturopathic treatment reasonable for most compensable personal injuries, occupational diseases or mental disorders. The Board may pay for extensions of treatment beyond eight weeks based on a review of the evidence.

7.2 Scope of Coverage

The Board determines whether it will pay for naturopathic remedies, treatments, or dietary supplements as part of an injured worker's claim.

Following approval, the Board may pay health care accounts submitted by a naturopathic physician, medical laboratory, or a radiologist, for tests and services performed by or on behalf of the naturopathic physician, as they relate to the worker's compensable personal injury, occupational disease or mental disorder.

8. NURSE PRACTITIONERS

Nurse practitioners in good standing with the applicable regulator responsible for governing nurse practitioners may provide nursing treatment and services to injured workers. Nurse practitioners may provide the nursing treatment and services authorized by the *Health Professions and Occupations Act* and corresponding regulation and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

EFFECTIVE DATE: October 21, 2020

AUTHORITY: Sections 1, 156, 157, 158, 160, 161, 163, and 164 of the *Act*.

CROSS REFERENCES: Sections 25(1) and 25(2) of the *Health Professions and Occupations Act,* S.B.C. 2022, c. 43*;*
Rehabilitation Services & Claims Manual, Volume II:
Item C3-23.00, *Replacement and Repair of Personal Possessions – Section 161(1)*;
Item C3-23.20, *Section 161(1)(b) − Eyeglasses, Dentures and Hearing Aids*;
Item C10-73.00, *Direction, Supervision, and Control of Health Care*;
Item C10-75.00, *Health Care Accounts – General*;
Item C10-78.00, *Health Care Facilities*;
Item C10-79.00, *Health Care Supplies and Equipment*;
Item C12-95.00, *Responsibilities of Physicians and Qualified Practitioners*;
Appendix 5, *Maximum Fines for Committing Offences Under the Act.*

HISTORY: April 1, 2026 – Housekeeping changes resulting from the replacement of the *Health Professions Act* with the *Health Professions and Occupations Act* and its regulations.
December 1, 2025 − Housekeeping change to update internal cross-reference, consequential to reformatting and renumbering Chapter 12, *Claims Procedures.*
October 21, 2020 – Amended to reflect amendment to the health care provisions in the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020.
September 1, 2020 − Policy amended to streamline language on pre-approval requirements.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
March 1, 2019 – Housekeeping changes were made as a result of amendments to various regulations under the Health Professions Act, effective September 4, 2018, creating name of British Columbia College of Nursing Professionals
Housekeeping changes made on January 1, 2018 as a result of the amendment of section 15(1) of the *Health Professions Act*, effective November 2, 2017.
January 1, 2015 – Policy amended to include nurse practitioners as qualified practitioners in accordance with change to the *Act*

resulting from the *Miscellaneous Statutes Amendment Act, 2014*, Bill 17 of 2014.
Policy also consolidated and replaced former policy items #74.00, #74.10, #74.20, #74.21, #74.22, #74.24, #74.27, #74.30, #74.40, #78.22 and #78.23 of the *Rehabilitation Services & Claims Manual,* Volume II, and included new policy on podiatrists.
June 1, 2009 – Deleted references to Board officer, Medical Advisor, Board Medical Advisor, Board's Chiropractic Consultant, Health Care Services Department, and claimant.
October 1, 2007 – Deleted references to memos and memorandums.
December 31, 2003 – This policy was amended to reflect the amendment of then section 5.1(1) of the *Act* and the introduction of then section 5.1(2) to (4) of the *Act.*
March 3, 2003 – Consequential changes were made as to references to review.

APPLICATION: Applies to health care expenses incurred and health care provided on or after October 21, 2020.

RE: Other Recognized Health Care Professionals **ITEM: C10-77.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance regarding an injured worker's entitlement to the services of recognized health care professionals, other than physicians and qualified practitioners.

2. The Act

Section 156:

See Item C10-72.00.

Section 157:

See Item C10-73.00.

Section 161, in part:

See Item C10-76.00.

Section 164, in part:

(1) Physicians, qualified practitioners or other persons authorized to provide health care under the compensation provisions [of the *Act*] must confine their treatment to injuries that are injuries to the parts of the body that they are authorized to treat under the Act under which they are permitted to practise.

(2) A person referred to in subsection (1) who gives treatment that is not authorized as referred to in that subsection commits an offence.

...

3. Health Professions and Occupations Act

Section 25, in part:

(1) The minister may, by regulation, designate a health profession as a designated health profession.

(2) A designation regulation made under this section must include regulations respecting all of the following:

(a) the name of the regulatory college that is responsible for governing the designated health profession;

(b) the titles that licensees practising the designated health profession may use exclusively;

(c) the types of health services that constitute the scope of practice of the designated health profession.

...

POLICY

1. DEFINITION

As set out in Item C10-72.00, "other recognized health care professionals" are health care professionals other than physicians and qualified practitioners, recognized by the Board through contracts and/or fee schedules, to provide health care to injured workers, such as acupuncturists, audiologists, community health workers, denturists, dietitians, massage therapists, nurses other than nurse practitioners, occupational therapists, opticians, optometrists, pharmacists, physiotherapists, prosthetists and orthotists, psychologists, and other mental health care providers.

2. AUTHORIZATION FOR HEALTH CARE SERVICES

The Board may authorize persons other than physicians or qualified practitioners to provide health care to injured workers.

The Board establishes the types of treatment and fees it pays for health care through contracts or by implementation of fee schedules, as appropriate. If there is no contract and/or fee schedule in place with respect to a certain type of health care, the Board pays an amount that it considers reasonable.

Generally, the Board pays in accordance with the rates set out in the current Board contracts and/or fee schedules in place at the time of service delivery, regardless of

whether the other recognized health care professional is a Board-authorized service provider under the contract and/or fee schedule.

Generally, the Board does not pay for health care that is new, non-standard or not generally accepted by the Board, unless prior Board approval has been obtained. The Board considers the scientific evidence and information regarding the effectiveness of such health care, when deciding whether to grant payment approval.

The Board only pays for the use of spas, public swimming pools or other exercise facilities as health care where the spa, public swimming pool or other exercise facility is used in the presence of another recognized health care professional as part of a Board-approved treatment program.

Generally, the Board only pays health care accounts for treatment provided to injured workers at their residence, when the injured worker is non-ambulatory and the visit is pre-approved by the Board.

3. GENERAL POSITION OF OTHER RECOGNIZED HEALTH CARE PROFESSIONALS

The Board's general position is that a worker should only be treated by one other recognized health care professional at a time.

Other recognized health care professionals are confined to treat injuries that are injuries to the parts of the body that they are authorized to treat by their governing Acts, regulations and bylaws. The Board may further limit the injuries and parts of the body they are authorized to treat. Other recognized health care professionals who give treatment that is not authorized by their governing Act commit an offence. The maximum fine for committing this offence is set out in Appendix 5 to this *Manual*.

The Board does not pay for a worker to attend other recognized health care professionals whose rights to provide health care have been cancelled or suspended either by the licensing body, or by the Board under the provisions referred to in Item C12-95.00.

Other recognized health care professionals are required to submit prompt, adequate and accurate reports to the Board. These reports should include information on the diagnosis, treatment possibilities, worker's prognosis, and, where appropriate, expectations for return to work.

4. ACUPUNCTURISTS

Licensees in good standing with the applicable regulator responsible for governing acupuncturists may provide acupuncture treatment and services to injured workers. Acupuncturists may provide the acupuncture treatment and services authorized by the *Health Professions and Occupations Act* and corresponding regulations and bylaws,

and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

The Board determines whether it will pay for acupuncture treatment and services as part of an injured worker's claim. The Board generally pays health care accounts for acupuncture treatment and services according to any current Board contract and/or fee schedule in place at the time of service delivery.

5. AUDIOLOGISTS

Licensees in good standing with the applicable regulator responsible for governing audiologists may provide audiology services to injured workers. Audiologists may provide the audiology services authorized by the *Health Professions and Occupations Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

The Board determines whether it will pay for audiology services as part of an injured worker's claim. The Board generally pays health care accounts for audiology services according to any current Board contract and/or fee schedule in place at the time of service delivery.

6. HEALTH CARE ASSISTANTS

Health care assistants include residential care aides, personal care attendants, registered care attendants, home support workers, rehabilitation aides, or nurses' aides. Health care assistants work under the direction and supervision of a physician, nurse practitioner, registered nurse or licensed practical nurse.

The Board determines whether it will pay for services by health care assistants as a part of an injured worker's claim. The Board generally pays health care accounts for services by health care assistants according to any current Board contract and/or fee schedule in place at the time of service delivery.

7. DENTURISTS

Licensees in good standing with the applicable regulator responsible for governing denturists may provide denturist services to injured workers. Denturists may provide the denturist services authorized by the *Health Professions and Occupations Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

The Board determines whether it will pay for denturist services as part of an injured worker's claim. The Board pays reporting or form fees to denturists for any reports that the Board requires, and generally pays health care accounts according to any current Board contract and/or fee schedule in place at the time of service delivery.

The Board may not pay for denturist services until it has received and approved an estimate from the denturist outlining:

- the extent of dental damage;
- the method of restoration recommended; and
- the expected costs of the repair, itemized according to the current Board contract and/or fee schedule in place at the time of service delivery.

8. DIETITIANS

Licensees in good standing with the applicable regulator responsible for governing dietitians may provide dietetic services to injured workers. Dietitians may provide the dietetic services authorized by the *Health Professions and Occupations Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

The Board determines whether it will pay for dietetic services as part of an injured worker's claim. The Board generally pays health care accounts for dietetic services according to any current Board contract and/or fee schedule in place at the time of service delivery.

9. MASSAGE THERAPISTS

Licensees in good standing with the applicable regulator responsible for governing massage therapists may provide massage therapy treatment and services to injured workers. Massage therapists and massage practitioners may provide the massage therapy treatment and services authorized by the *Health Professions and Occupations Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

The Board determines whether it will pay for massage therapy treatment and services as a part of an injured worker's claim. The Board generally pays health care accounts for massage therapy treatment and services according to any current Board contract and/or fee schedule in place at the time of service delivery.

10. NURSES

Registered nurses, registered psychiatric nurses and licensed practical nurses in good standing with the applicable regulator responsible for governing nurses may provide nursing treatment and services to injured workers. Nurses may provide the nursing treatment and services authorized by the *Health Professions and Occupations Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

For workers who need nursing services while in a hospital, the necessary nursing service is determined and provided by the hospital. If the worker or the worker's family desires to have an additional or one-on-one nurse in attendance, the worker pays the cost of such nursing services.

The Board determines whether it will pay for nursing treatment and services as a part of an injured worker's claim. The Board generally pays health care accounts for nursing treatment and services according to any current Board contract and/or fee schedule in place at the time of service delivery.

The Board accepts reports received from nurses in remote locations as medical reports if there is no physician in the immediate area.

11. OCCUPATIONAL THERAPISTS

Licensees in good standing with the applicable regulator responsible for governing occupational therapists may provide occupational therapy treatment and services to injured workers. Occupational therapists may provide the occupational therapy treatment and services authorized by the *Health Professions and Occupations Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

The Board determines whether it will pay for occupational therapy treatment and services as part of an injured worker's claim. The Board generally pays health care accounts for occupational therapy treatment and services according to any current Board contract and/or fee schedule in place at the time of service delivery.

12. OPTICIANS

Licensees in good standing with the applicable regulator responsible for governing opticians may provide opticianry services to injured workers. Opticians and dispensing opticians may provide the opticianry services authorized by the *Health Professions and Occupations Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

The Board determines whether it will pay for opticianry services as part of an injured worker's claim. The Board generally pays health care accounts for opticianry services according to any current Board contract and/or fee schedule in place at the time of service delivery.

13. OPTOMETRISTS

Licensees in good standing with the applicable regulator responsible for governing optometrists may provide optometry treatment and services to injured workers. Optometrists may provide the optometry treatment and services authorized by the *Health Professions and Occupations Act* and corresponding regulations and bylaws,

and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

The Board determines whether it will pay for optometry treatment and services as part of an injured worker's claim. The Board generally pays health care accounts for optometry treatment and services according to any current Board contract and/or fee schedule in place at the time of service delivery.

14. PHARMACISTS

Licensees in good standing with the applicable regulator responsible for governing pharmacists may provide pharmacy services to injured workers. Pharmacists may provide the pharmacy services authorized by the *Health Professions and Occupations Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

The Board determines whether it will pay for pharmacy services as part of an injured worker's claim. The Board generally pays health care accounts for pharmacy services according to any current Board contract and/or fee schedule in place at the time of service delivery.

15. PHYSIOTHERAPISTS

Licensees in good standing with the applicable regulator responsible for governing physiotherapists may provide physical therapy treatment and services to injured workers. Physical therapists and physiotherapists may provide the physical therapy treatment and services authorized by the *Health Professions and Occupations Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

The Board determines whether it will pay for physical therapy treatment and services as part of an injured worker's claim. The Board generally pays health care accounts for physical therapy treatment and services according to any current Board contract and/or fee schedule in place at the time of service delivery.

16. PROSTHETISTS AND ORTHOTISTS

Registered members in good standing with the relevant governing body for prosthetists and orthotists may provide prosthetic or orthotic services and devices to injured workers. Prosthetists and orthotists may provide prosthetic or orthotic services and devices as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

The Board determines whether it will pay for prosthetic or orthotic services and devices as part of an injured worker's claim. The Board generally pays health care accounts for

prosthetic or orthotic services and devices according to any current Board contract and/or fee schedule in place at the time of service delivery.

17. PSYCHOLOGISTS AND COUNSELLORS

Licensees in good standing with the applicable regulator responsible for governing psychologists may provide psychological treatment and services to injured workers. Psychologists may provide psychological treatment and services as authorized by the *Health Professions and Occupations Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

Registered clinical counsellors in good standing with the relevant governing body, or Canadian certified counsellors in good standing with the relevant governing body, may provide counselling treatment and services to injured workers. Registered clinical counsellors and Canadian certified counsellors may provide counselling treatment and services as authorized by their governing bodies and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

The Board determines whether it will pay for psychological or counselling treatment and services as part of an injured worker's claim. The Board generally pays health care accounts for psychological or counselling treatment and services according to any current Board contract and/or fee schedule in place at the time of service delivery.

When psychological or counselling treatment and/or services are required, the Board arranges for a psychologist or counsellor to provide treatment and/or services to the worker according to any current Board agreement and/or accompanying guideline in place at the time of service delivery.

EFFECTIVE DATE:	July 4, 2025
AUTHORITY:	Sections 156, 157, 161, and 164 of the *Act*.
CROSS REFERENCES:	Sections 25(1) and 25(2) of the *Health Professions and Occupations Act,* S.B.C. 2022, c. 43*;* *Rehabilitation Services & Claims Manual*, Volume II: Item C10-73.00, *Direction, Supervision, and Control of Health Care*; Item C10-75.00, *Health Care Accounts – General*; Item C10-79.00, *Health Care Supplies and Equipment*; Item C10-84.00, *Additional Benefits for Severely Disabled Workers*; Appendix 5, *Maximum Fines for Committing Offences Under the Act.*
HISTORY:	April 1, 2026 – Housekeeping changes resulting from the replacement of the *Health Professions Act* with the *Health Professions and Occupations Act* and its regulations. December 1, 2025 − Housekeeping change to update internal

cross-reference, consequential to reformatting and renumbering Chapter 12, *Claims Procedures.*
July 4, 2025 − Policy amended to remove reference to specific governing bodies and to make the language more general and consistent throughout. Policy also amended to update the term community health workers with the term health care assistants, and to add registered psychiatric nurses to the list of nurses that may provide treatment and services.
September 1, 2024 − Housekeeping change to update title of College of Health and Care Professionals of British Columbia.
September 1, 2020 − Policy amended to increase acupuncture coverage and streamline language on pre-approval requirements.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
March 1, 2019 − Housekeeping changes were made as a result of amendments to various regulations under the *Health Professions Act*, effective September 4, 2018, creating name of British Columbia College of Nursing Professionals.
January 1, 2018 – Housekeeping changes were made as a result of the amendment of section 15(1) of the *Health Professions Act*, which came into effect November 2, 2017.
January 1, 2015 – Policy amended to remove reference to nurse practitioners as other recognized health care professionals. Policy also incorporated the concepts from and replaced former policy items #75.00, #75.10, #75.12, #75.20, #75.30, #75.40 and #78.14 of the *Rehabilitation Services & Claims Manual,* Volume II, and included new policy on audiologists, community health workers, dieticians, massage therapists, occupational therapists, opticians, optometrists, pharmacists, prosthetists and orthotists, and psychologists and counsellors.
June 1, 2009 – Deleted references to Board officer, Unit or Area Office Medical Advisor, and Board Medical Advisor and Consultant.

APPLICATION: This Item applies to health care expenses incurred and health care provided on or after July 4, 2025.

RE: Health Care Facilities **ITEM: C10-78.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the payment of health care accounts for services provided at health care facilities.

2. The Act

Section 156:

See Item C10-72.00.

Section 157:

See Item C10-73.00.

Section 158:

See Item C10-73.00.

POLICY

1. GENERAL

As set out in Item C10-72.00, “health care facility” means a hospital; surgical facility; office of a physician, qualified practitioner or other recognized health care professional; group home; or other place where acute, intermediate or long-term health care services or programs, are provided.

The Board pays for health care provided at health care facilities that the Board considers reasonably necessary in the diagnosis and treatment of an injured worker. This includes, but is not limited to, emergency services, laboratory tests and diagnostic imaging services.

Prior Board approval is normally required for diagnostic imaging services, such as MRIs, PET Scans and CT scans. Where prior Board approval is not obtained, the Board may still pay the health care account in emergency situations or where the Board determines that the procedure was reasonably necessary.

The Board pays for medically necessary supplies, assistive devices or appliances, approved by the Board, that are provided by the health care facility to the worker for the worker's use following discharge from the facility. Examples of such items include, but are not limited to, crutches, braces and casts.

The amounts payable to health care facilities for health care provided to injured workers are generally governed by contracts and/or fee schedules negotiated by the Board.

2. OVERNIGHT STAY

Where in-patient per diem rates are paid to health care facilities, such rates are inclusive of all essential costs associated with an overnight stay including additional nursing services, special beds, medications, or any other additional services or equipment.

The Board pays for accommodation in a standard ward. The Board may pay for private or semi-private accommodation where it is cost effective in minimizing wage-loss benefits resulting from a delayed admission to the health care facility, or if the Board considers such accommodation to be reasonably necessary due to the nature of the compensable personal injury, occupational disease or mental disorder.

The Board may pay for the cost of telephone and television rentals where the worker is required to remain in a health care facility for longer than one night.

3. HEALTH CARE FACILITIES OTHER THAN ACUTE CARE HOSPITALS

Health care facilities other than acute care hospitals may be used for the pre-operative or post-operative treatment of injured workers who require active nursing services, or for operative purposes, if a worker requires expedited surgery. The Board only pays for health care at this type of facility where Board approval has been obtained before the worker is admitted.

Where prior Board approval is not obtained, the Board may pay for the health care provided where the Board determines that the health care was reasonably necessary. The Board establishes rates for payment, taking into consideration such things as:

- the purpose and necessity of the health care;
- the level of care required; and/or
- the regulatory authority of the health care facility.

4. REDUCTION OR SUSPENSION OF COMPENSATION

The Board's approval must be obtained for any absence from a health care facility for any purpose other than medical treatment and examination. The Board does not pay

for an overnight stay in a health care facility during such a period of absence unless prior Board approval for the absence has been obtained.

Cases of a worker's misconduct, while admitted to a health care facility, may result in the Board reducing or suspending the worker's compensation if the circumstances in Item C10-74.00 are met.

EFFECTIVE DATE:	January 1, 2015
AUTHORITY:	Sections 156, 157, and 158 of the *Act*.
CROSS REFERENCES:	Item C7-49.00, *Incapacity of a Worker*; Item C10-72.00, *Health Care – Introduction*; Item C10-73.00, *Direction, Supervision, and Control of Health Care*; Item C10-74.00, *Reduction or Suspension of Compensation*; Item C10-77.00, *Other Recognized Health Care Professionals*; Item C10-79.00, *Health Care Supplies and Equipment*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. January 1, 2015 − This policy consolidated and replaced former policy items #76.00, #76.10, #76.30, #76.40 and #76.50 of the *Rehabilitation Services & Claims Manual*, Volume II. June 1, 2009 – Deleted reference to Board officer.
APPLICATION:	This Item applies to health care expenses incurred and health care provided on or after January 1, 2015.

RE: Health Care Supplies and Equipment **ITEM: C10-79.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on an injured worker's entitlement to, and the repair and replacement of, health care supplies and equipment.

2. The Act

Section 155:

(1) To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

(2) If compensation is payable under this Part [Part 4 of the *Act* – Compensation to Injured Workers and Their Dependants] as the result of the death of a worker, the Board may make provisions and expenditures for the training or retraining of a dependent spouse, regardless of the date of death.

(3) The Board may, if it considers this advisable, provide counselling and placement services to dependants of a worker.

Section 156:

See Item C10-72.00.

Section 161(2):

If an injury to a worker results in serious impairment of the worker's sight, the Board may, for the purpose of protecting the worker's remaining vision, provide the worker with protective eyeglasses.

POLICY

1. GENERAL

The Board may pay for health care supplies and equipment that the Board considers reasonably necessary to cure or alleviate the effects of the worker's personal injury, occupational disease or mental disorder, and to assist in recovery. The Board considers medical opinion or other expert professional advice and cost effectiveness in making this determination.

Health care supplies and equipment may be provided on a temporary or a permanent basis.

Optional upgrades on health care supplies and equipment that are not medically necessary to alleviate the effects of the compensable disability are at the worker's own expense.

1.1 Repair and Replacement of Health Care Supplies and Equipment

The Board may pay for the repair and/or maintenance of health care supplies and equipment. In paying for repair and/or maintenance, the Board may establish an allowance in lieu of requiring ongoing submission of receipts. The amount of the allowance is based on the Board's experience as to the normal wear and tear, maintenance requirements and life span of the item in question.

The Board may pay for replacement of health care supplies and equipment when there is a demonstrated deficiency or deterioration in the item, there is a change in the worker's condition such that the item no longer meets the worker's needs, the item cannot be cost effectively repaired, and/or the item jeopardizes the worker's safety. Replacement of health care supplies and equipment is based on the Board's experience as to the normal wear and tear and life span of the item in question.

The Board may not pay for the repair or replacement of health care supplies and equipment if the loss or damage is a result of deliberate misuse, abuse, or occurs with excessive frequency.

2. TYPES OF HEALTH CARE SUPPLIES AND EQUIPMENT

Set out below are some of the health care supplies and equipment paid for by the Board and the conditions and criteria for their coverage. The list is not exhaustive. A worker or the worker's physician, qualified practitioner or other recognized health care professional may contact the Board to determine if the Board will pay for a particular item.

2.1 Medical Supplies

The Board may pay for medical supplies required to treat a worker's compensable personal injury, occupational disease or mental disorder where recommended by the worker's physician, qualified practitioner or other recognized health care professional. The Board may require medical or other expert professional reports to support the necessity of specific medical supplies.

2.1.1 Prescription Medications

The Board may pay for prescription medication where the Board determines that it is reasonably necessary to treat the worker's compensable disability. The Board generally pays for medications at the equivalent generic drug rate.

Payment for opioids, sedatives/hypnotics, and other potentially addictive drugs are discussed in Item C10-80.00.

2.1.2 Prescription Eyeglasses

The Board may pay for prescription eyeglasses for workers whose eyesight is affected as a result of a compensable personal injury or occupational disease. The Board may pay for tinted lenses if required for the compensable disability and if prescribed by a physician or qualified practitioner.

The Board may pay for contact lenses if the Board considers they would be more appropriate for the compensable personal injury or occupational disease and more beneficial to the worker than prescription eyeglasses.

If a worker loses the sight or a substantial part of the sight of one eye due to a compensable personal injury or occupational disease, the Board may pay for protective glasses with hardened lenses to protect the remaining vision. The Board may also pay for an ocular prosthesis (artificial eye) if it considers the ocular prosthesis to be reasonably necessary.

In all cases, the Board establishes the rates of payment for prescription eyeglasses, contact lenses and protective eyewear.

2.1.3 Hearing Aids

A worker with a work-related hearing loss may be eligible to receive a hearing aid, depending on the level of hearing loss. The Board determines the level of hearing loss, with advice from a certified audiologist. The Board establishes rates for the provision of hearing aids by contracting with Board-authorized service providers.

If a hearing aid is not obtained from a Board-authorized service provider, any additional costs incurred by the worker, beyond the Board-established rates for the provision of hearing aids, are at the worker's own expense.

Special accessories for the hearing aid (e.g. a telephone amplifier) may be paid for in cases where it is considered reasonably necessary by the Board.

The Board may pay for a bilateral hearing aid where required due to a worker's level of hearing loss.

2.2 Artificial Appliances

The Board pays for the most medically and functionally appropriate and cost effective artificial appliances. In making this determination, the Board may consider, among other factors, whether:

- the appliance is required due to a compensable personal injury or occupational disease;
- the appliance is prescribed by the worker's physician or qualified practitioner; and/or
- the provision of the artificial appliance is supported by objective medical evidence or other expert professional advice.

2.2.1 Prosthetic Appliances

The Board only pays for prosthetic appliances if they are requisitioned from facilities that have registered prosthetists or similarly qualified professionals on their staff.

The Board may pay for cosmetic restoration for aesthetic rather than functional purposes in order to alleviate the impact of the compensable disability and promote social and psychological well-being. Examples of cosmetic restoration include, but are not limited to, skin matching, artificial fingers or partial hands, artificial noses, and artificial ears.

The Board may establish guidelines with respect to the provision of advanced technologies, such as myoelectric and computerized prostheses.

2.2.2 Orthotic Appliances

The Board may pay for orthotic appliances on one or more occasions to assist with recovery, improve or maintain functional abilities, and to assist with return to work.

Examples of orthotic appliances include, but are not limited to, spinal or leg braces, back braces, or splints.

2.3 Footwear

The Board may pay for customized or commercial footwear when the Board determines that the provision of footwear is warranted due to the compensable disability. The Board may also pay where customized or commercial footwear is a requirement for treatment or rehabilitation or where the worker's existing footwear is not sufficient or cannot be adequately modified.

In making this determination, the Board considers whether the provision of footwear will enable the worker to return to work and to meet any workplace safety requirements. The Board generally pays for footwear for a worker with a temporary disability on a one-time only basis.

In all cases, when the worker's disability warrants the provision of footwear, either customized or commercial, the Board pays for the most medically appropriate and cost effective alternative.

2.4 Mobility-Related Devices

The Board may pay for mobility-related devices to assist permanently disabled workers with activities of daily living and/or instrumental activities of daily living that the worker is unable to carry out due to the compensable personal injury or occupational disease. The Board makes its determination on the provision of mobility-related devices based on medical opinion, other expert professional advice, and the cost effectiveness of the device. Examples of mobility-related devices include, but are not limited to, canes, crutches, walkers, manual wheelchairs, scooters and power wheelchairs.

The Board may rent a mobility-related device for a worker whose temporary disability severely restricts the worker's mobility and the device is medically necessary to address the worker's mobility needs.

The Board pays for wheelchairs for workers who are permanently disabled and whose ability to walk is so severely restricted that the use of any other mobility device, including a mobility scooter, is insufficient to address the worker's mobility needs. The Board determines the type of wheelchair to purchase, either manual or power, based on medical opinion or other expert professional advice establishing necessity and cost effectiveness. The Board may rent a wheelchair for a worker whose temporary disability severely restricts the worker's mobility, and the use of any other mobility-related device is insufficient to address the worker's mobility needs.

2.5 Recreational Prosthetic Appliances and Mobility Devices

The Board may pay for recreational prosthetic appliances, mobility devices, or specialized sports devices for exercise purposes in certain circumstances. In determining whether a recreational prosthetic appliance, mobility device, or specialized sports device is appropriate, the Board considers the following:

- the physical and psychological benefits to the worker;
- the worker's demonstrated ability to maintain an active lifestyle;
- the physical ability of the worker to use the equipment independently and safely;
- the potential risk of additional injuries to the worker;
- the assessment of the equipment and its reliability;
- the cost effectiveness; and
- any previous recreational prosthetic appliances, mobility devices, or specialized sports devices supplied to the worker.

The Board normally pays for recreational prosthetic appliances, mobility devices, or specialized sports devices for one recreational activity at a time. The Board may pay for another recreational prosthetic appliance, mobility device, or specialized sports device when the Board determines that the previously provided device is no longer appropriate.

2.6 Miscellaneous Items

The Board may pay for miscellaneous health care supplies and equipment that it considers reasonably necessary for the health care needs of an injured worker, or that are designed to assist with the activities of daily living.

Examples of such items include, but are not limited to:

- raised toilet seats and commodes;
- wheelchair and pressure relief cushions;
- hand held shower heads, grab bars, bath benches, non-slip bath mats, and safety poles;
- long-handled shoe horns and elastic shoelaces; and

- supplies to assist with personal hygiene such as tubing, urinary drainage bags, catheters, suppositories, disposable gloves, and other bladder and bowel routine care supplies.

For workers who require an adjustable bed due to the compensable personal injury or occupational disease, the Board may also pay for items such as:

- adjustable hospital-type beds and adjustable bed mattresses; and/or
- pressure relieving mattresses or overlays where needed to prevent skin breakdown or spasm.

Generally, the Board does not pay for general household items such as hot tubs, televisions, linens and furniture.

EFFECTIVE DATE:	January 1, 2015
AUTHORITY:	Sections 155, 156, and 161 of the *Act*.
CROSS REFERENCES:	Item C3-23.00, *Replacement and Repair of Personal Possessions – Section 161(1)*; Item C10-77.00, *Other Recognized Health Care Professionals*; Item C10-78.00, *Health Care Facilities*; Item C10-80.00, *Potentially Addictive Drugs*; Item C10-81.00, *Home and Vehicle Modifications*; Item C10-82.00, *Clothing Allowances*; Item C10-84.00, *Additional Benefits for Severely Disabled Workers*; Chapter 11 – Vocational Rehabilitation, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. January 1, 2015 − This policy consolidated concepts and replaced former policy items #74.26, #77.00, #77.10, #77.20, #77.21, #77.22, #77.23, #77.24, #77.25, #77.26, #77.28, and #77.29 of the *Rehabilitation Services & Claims Manual*, Volume II. June 1, 2009 – Deleted references to Board officer, Board Medical Advisor, Health Care Services Department, Board's Special Care Services Department, Board's Rehabilitation Centre, and inserted reference to prosthetist.
APPLICATION:	This Item applies to health care expenses incurred and health care provided on or after January 1, 2015.

RE: Potentially Addictive Drugs **ITEM: C10-80.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance regarding the authorization of payment for potentially addictive drugs.

2. The Act

Section 156:

See Item C10-72.00.

Section 157:

See Item C10-73.00.

POLICY

1. GENERAL

The Board may pay for potentially addictive drugs prescribed to an injured worker following the worker's injury or most recent surgery; or for the treatment of conditions arising from the worker's compensable personal injury, occupational disease or mental disorder.

The Board generally only pays for prescribed potentially addictive drugs that are administered orally, except in immediate post-injury, operative, peri-operative or palliative situations.

The following sections set out when the Board pays for the prescription of opioids, sedatives/hypnotics or other potentially addictive drugs. A list of specific potentially addictive drugs covered by this policy may be obtained by contacting the Board.

2. AUTHORIZATION FOR PRESCRIBED OPIOIDS

The Board may pay for prescribed opioids for up to four weeks. The Board does not consider payment beyond four weeks appropriate in most cases.

In exceptional cases, the Board may pay for extensions of opioid prescriptions beyond four weeks if, among other considerations:

- there is objective medical opinion or other expert professional advice that treatment with opioids is resulting in improvement of pain and function, enabling the worker to return to work, perform activities of daily living, and/or perform instrumental activities of daily living; and

- the use of opioids is part of an integrated approach to overall pain management.

The Board does not pay for extensions of opioid prescriptions until it has received and approved a request from the physician or qualified practitioner outlining details such as the treatment plan, dosage, frequency, and progress expectations.

The Board also requires the worker to complete a written treatment agreement outlining the conditions of the extension being granted.

As part of the Board's integrated approach to overall pain management, the Board reviews long-term treatment plans involving the use of opioids on a periodic basis. The Board also refers to best practice treatment guidelines and other expert scientific and medical evidence on the treatment and management of opioids and other potentially addictive drugs.

3. AUTHORIZATION FOR PRESCRIBED SEDATIVES/HYPNOTICS

The Board may pay for prescribed sedatives/hypnotics for up to two weeks. The Board does not consider payment beyond two weeks appropriate in most cases.

In exceptional cases, the Board may pay for extensions of sedative/hypnotic prescriptions beyond two weeks if, among other considerations:

- the Board has accepted a psychological condition under the claim and the worker is under the care of a psychiatrist;

- the sedative/hypnotic medication is prescribed to treat spasticity associated with a compensable condition such as a spinal cord injury, or

- the extension is for a short duration (one to two days) and is associated with an upcoming scheduled medical investigation or procedure.

4. AUTHORIZATION FOR OTHER PRESCRIBED POTENTIALLY ADDICTIVE DRUGS

The Board does not pay for any other potentially addictive drugs prescribed to an injured worker, unless their use is part of an integrated approach to overall pain management and the Board has received:

- a request from the physician or qualified practitioner outlining details such as the treatment plan, dosage, frequency, and progress expectations; and
- a written treatment agreement, which outlines the conditions of payment, signed by the worker.

5. CANCELLATION OF PAYMENT FOR ALL PRESCRIBED POTENTIALLY ADDICTIVE DRUGS

The Board may restrict or discontinue the authorization of payment for prescribed potentially addictive drugs if, among other considerations, the Board determines that:

- the worker's pain and/or function has improved completely or significantly, and treatment with the potentially addictive drug is no longer medically necessary;
- there is no improvement in the worker's pain and/or function;
- the prescribed potentially addictive drug results in adverse side effects;
- the worker is in contravention of one or more of the conditions set out in the worker's written treatment agreement; or
- there is a reasonable risk of misuse.

6. EXCEPTIONS

In cases where a worker is receiving palliative care, the Board may determine the duration of a worker's entitlement to prescribed potentially addictive drugs based on the physician or qualified practitioner's treatment plan and the individual merits of the case.

EFFECTIVE DATE:	January 1, 2015
AUTHORITY:	Sections 156 and 157 of the *Act*.
CROSS REFERENCES:	Item C10-79.00, *Health Care Supplies and Equipment*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*,

R.S.B.C. 2019, c. 1.
January 1, 2015 − This policy replaced former policy item #77.30 of the *Rehabilitation Services & Claims Manual*, Volume II.
June 1, 2009 – Deleted references to Board officer, Payment officer and Board Medical Advisor.

APPLICATION: This Item applies to health care expenses incurred and health care provided on or after January 1, 2015.

RE: Home and Vehicle Modifications **ITEM: C10-81.00**

BACKGROUND

1. Explanatory Notes

This policy sets out an injured worker's entitlement to home and/or vehicle modifications.

2. The Act

Section 156:

See Item C10-72.00.

Section 157:

See Item C10-73.00.

POLICY

1. GENERAL

The Board may pay for home and/or vehicle modifications where they are required due to a compensable personal injury or occupational disease. The Board retains ownership of the modifications and may reclaim them when they are no longer required.

2. HOME MODIFICATIONS

The Board may pay for home modifications that are reasonably necessary to improve a worker's access to areas of the worker's home and to assist with activities of daily living. In making this determination, the Board considers:

- the nature and severity of the worker's disability;
- the expected duration of the worker's disability (i.e. whether it will be temporary or permanent);
- the medical necessity of the modifications requested;
- the scope of the modifications requested;

- the suitability of the worker's home for modification:
  - whether the home is structurally sound;
  - whether the modifications are a viable option; and
  - whether the worker owns or rents the home;
- the cost effectiveness of the proposed modifications; and
- whether any alternative modifications may be more appropriate to address the impact of the worker's disability or functional needs.

Prior approval by the Board is required for payment of any home modifications. Any unauthorized modifications or upgrades may be at the worker's own expense.

If necessary, the Board may relocate the worker to a suitable temporary accommodation during the home modification process.

Minor home modifications may include, but are not limited to: the installation of grab-bars, ceiling poles, hand rails, handheld showers, or wing taps for sinks.

The Board may pay for minor home modifications for workers who own or rent the home they live in. Where applicable, the Board requires written authorization from a landlord, strata corporation, cooperative, or similar entity, prior to any modifications to the home.

The Board may pay for minor home modifications on more than one occasion based on the Board's assessment of the worker's continued need for the home modifications, with reference to the factors listed above.

The Board may pay for major home modifications for severely disabled workers as set out in Item C10-84.00.

3. VEHICLE MODIFICATIONS

The Board may pay for vehicle modifications that are reasonably necessary to improve a worker's mobility and independence outside of the home, and to address the transportation and access needs of the worker. In making this determination, the Board considers:

- the nature and severity of the worker's disability;
- the expected duration of the worker's disability (i.e., whether it will be temporary or permanent);

- the medical necessity of the modifications requested;
- the scope of the modifications requested;
- the suitability of the worker's vehicle for modification:
  - whether the transmission is automatic or manual; and/or
  - whether the vehicle is large enough for the modifications required;
- the cost effectiveness of the proposed modifications;
- if the worker is driving the vehicle, whether the worker is eligible to drive;
- if the worker is not driving the vehicle, the intended driver of the vehicle; and
- whether any alternative modifications may be more appropriate to address the impact of the worker's disability or functional needs.

Prior approval by the Board is required for payment of any vehicle modifications. Any unauthorized modifications or upgrades may be at the worker's own expense. Only the worker's primary vehicle is modified.

Minor vehicle modifications may include, but are not limited to: hand controls, parking brake extension levers, power parking brakes, left hand gear selection levers, spinner knobs for steering wheels, gas guards, chest harnesses/seatbelts, or pedal extensions.

The Board may pay for minor vehicle modifications for workers who own or lease their vehicle. If the worker leases a vehicle, written authorization from the lessor is also necessary prior to any modification to the leased vehicle.

The Board may pay for minor vehicle modifications on more than one occasion based on the Board's assessment of the worker's continued need for the vehicle modification, with reference to the factors listed above.

The Board may pay for major vehicle modifications for severely disabled workers as set out in Item C10-84.00.

4. MAINTENANCE AND REPAIRS OF HOME AND VEHICLE MODIFICATIONS

The Board does not pay the cost of general maintenance and repairs of homes and/or vehicles that would be required regardless of the compensable personal injury or occupational disease, even if some equipment has been supplied by the Board.

The Board may pay for the maintenance and/or repair of home and/or vehicle modifications that are specifically required due to the worker's compensable personal injury or occupational disease.

The worker is responsible for any repair and/or maintenance costs of home and vehicle modifications resulting from deliberate misuse or abuse by the worker.

If a worker's home and/or vehicle insurance premiums increase due to a home or vehicle modification, the Board may pay for the amount of the increase.

EFFECTIVE DATE:	January 1, 2015
AUTHORITY:	Sections 156 and 157 of the *Act*.
CROSS REFERENCES:	Item C7-48.10, *Overpayments/Money Owed to the Board*; Item C10-79.00, *Health Care Supplies and Equipment*; Item C10-84.00, *Additional Benefits for Severely Disabled Workers*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. January 1, 2015 − This policy replaced former policy item #77.27 of the *Rehabilitation Services & Compensation Manual,* Volume II. June 1, 2009 – Deleted references to Board officer.
APPLICATION:	This Item applies to health care expenses incurred and health care provided on or after January 1, 2015.

RE: Clothing Allowances **ITEM: C10-82.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on a worker's entitlement to clothing allowances.

2. The Act

Section 156:

See Item C10-72.00.

POLICY

1. GENERAL

The Board may pay the clothing allowances set out below to upper and/or lower limb amputees wearing prostheses, and to workers wearing an upper or lower limb brace, or a back brace. The amputation must be at or above the wrist, or at or above the ankle. An upper limb brace is a brace worn at or above the wrist. The brace must be either a major joint brace with rigid frame or contain rigid materials; or a hard back brace, with a rigid frame or shell.

Workers are paid a clothing allowance under one category as set out below:

	Jan. 1, 2025 – Dec. 31, 2025	Jan. 1, 2026 – Dec. 31, 2026
Upper Limb	$431.18	$440.51
Lower Limb	$864.47	$883.17
Bilateral Limb	$864.47	$883.17
Upper and Lower Limb	$1,295.78	$1,323.81

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

The Board also pays the allowance to a worker confined to a wheelchair, who is not otherwise entitled, at the upper and lower limb rate. The Board pays the allowance to a worker wearing a back brace at the upper and lower limb rate.

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

The Board automatically pays the clothing allowance to a worker with an amputation at or above the wrist, or at or above the ankle. Proof is not required of the wearing of the prosthesis or prostheses, nor of the replacement, repair, or damage to clothing. In the case of braces however, the Board only pays the clothing allowance contingent on the worker's continued wearing of the apparatus as prescribed. Similarly, in the case of a worker confined to a wheelchair, the Board only pays the clothing allowance contingent on the worker's continued use of the wheelchair as prescribed.

Entitlement to the clothing allowance commences as of the date of the amputation or the worker commencing to use the brace or wheelchair. The Board makes the first payment following the initiation of the permanent disability benefits payments and this first payment includes any retroactive entitlement for prior periods of disability not previously paid. Subsequent payments are made annually.

The Board withholds payment of the clothing allowance while a worker is in prison. The Board pays the amount withheld to the worker on release, if the period in prison was less than one year. If the period in prison was more than one year, the Board does not pay the clothing allowance for each full year the worker was in prison.

EFFECTIVE DATE:	January 1, 2018
AUTHORITY:	Section 156 of the *Act.*
CROSS REFERENCES:	Item C10-79.00, *Health Care Supplies and Equipment*; Item C10-84.00, *Additional Benefits for Severely Disabled Workers*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:

April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
January 2018 – This policy was amended to provide additional clarification of the categories in the clothing allowance table; more guidance on what type of brace qualifies for an allowance; clarification that an allowance is payable under one category only; and the method and timing of payments was updated.
January 1, 2015 − This policy replaced former policy item #79.00 of the *Rehabilitation Services & Claims Manual,* Volume II.
October 1, 2007 – This policy was revised to change the reference to the date of clothing allowance adjustments from July to January 1st of each year.

APPLICATION:

This Item applies to health care expenses incurred and health care provided on or after January 1, 2018.

RE: Transportation **ITEM: C10-83.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on when the Board pays transportation costs as health care.

2. The Act

Section 156:

> See Item C10-72.00.

Section 159(2):

> If a worker is injured in the course of employment, the worker's employer must, at the employer's own expense, provide the injured worker, when necessary, with immediate conveyance and transportation to a hospital, physician or qualified practitioner for initial treatment.

Section 160:

> See Item C10-73.00.

POLICY

1. DEFINITIONS

As set out in Item C10-72.00, "residence" means the place where a worker lives or regularly stays. Where the worker has more than one residence, the worker is required to identify one as the primary residence.

As set out in Item C10-73.00, a "medical examination" is not limited to examinations performed by physicians. It also includes examinations by qualified practitioners and other recognized health care professionals. The term "examination" may include a consultation (e.g., with a dentist), or an assessment (e.g., by a psychologist).

2. ELIGIBILITY

The Board may pay for transportation for a worker to receive Board-approved health care for a compensable personal injury, occupational disease or mental disorder.

Transportation costs may be paid where the distance between the point of origin and the destination is 20 kilometres or greater, one way, for:

(a) travel to a health care facility to obtain Board-approved health care;

(b) visits to the worker's residence while the worker is participating in a Board-approved health care program lasting six weeks or more, during which the worker is required to stay in other accommodation. The Board may pay for transportation in respect of such visits once every three weeks, if the worker's recovery would not be impeded;

(c) return travel to the worker's residence if, at the time of the compensable personal injury, occupational disease or mental disorder, the worker is working at a location other than the worker's resident community, and the worker's disability from the compensable personal injury, occupational disease or mental disorder prevents the worker from returning to the worker's place of residence using the worker's usual mode of transportation; or

(d) travel in connection with attendance at a Board- or Workers' Compensation Appeal Tribunal-directed medical examination or inquiry.

Transportation costs are not normally paid for:

(a) The first 20 kilometres of any journey, except where the Board determines that the worker's condition is such as to require travel by:

- ambulance or other method of emergency transportation (not including the date of injury transportation as per section 159); or
- taxi.

(b) travel related to attendance at a return to work program; or

(c) the portion of any journey which takes place beyond the boundary of British Columbia. This does not apply where the Board specifically requests the worker to attend a medical examination, or in certain situations specified in Item C12-100.10, in relation to claims or Review Division inquiries.

To determine the amount payable for transportation, the Board considers the most reasonably direct route available from the point of origin to the destination. The point of origin is usually the worker's residence.

Where a worker is required to travel to attend a vocational rehabilitation appointment, other than as part of a vocational rehabilitation plan, the Board pays for transportation in the same manner and at the same rates as set out in this policy. Where a worker is participating in a vocational rehabilitation plan, the Board may establish the amount paid for transportation separately as part of that plan.

2.1 Worker Bypasses Nearby Health Care Facilities

Workers may choose to bypass adequate health care facilities and travel a further distance to attend a particular physician, qualified practitioner or other recognized health care professional of their own choice. Subject to the Board's authority to direct, supervise and control treatment, workers may select their own physician, qualified practitioner or other recognized health care professional.

However, the Board may place limits on the transportation it pays for when a worker bypasses adequate nearby health care facilities and incurs additional transportation costs to attend another health care facility because of personal preference. In cases where the Board determines that travelling a further distance to a health care facility is not reasonably necessary, the Board only pays for transportation in respect of travel to the nearest health care facility that the Board considers adequate.

If a worker moves residence to another location while receiving compensation, the Board will use the worker's new residence as the point of origin for determining the worker's eligibility. In these situations, the Board does not normally pay:

(a) the cost of the move from one place of residence to another as health care; or

(b) increased transportation costs for a worker to bypass an adequate health care facility to attend a physician, qualified practitioner or other recognized health care professional in the worker's former resident community simply on the basis of the worker's personal preference.

If a worker receiving health care benefits moves out of British Columbia, the Board pays for transportation in accordance with the amounts payable as set out in section 5 of this policy and on the same basis as if the worker continued to reside in British Columbia.

3. MODE OF TRANSPORTATION

When evaluating the most appropriate mode of transportation, the Board may consider:

- the nature and extent of the worker's compensable personal injury, occupational disease or mental disorder;
- any pre-existing medical and/or psychological conditions;
- the urgency of the health care;
- any potential safety issues with various modes of transportation;
- availability of particular travel modes;
- travel times and distance;
- worker's travel preference and convenience;
- expected weather and road conditions during travel; and
- cost of the mode of transportation.

Following these considerations, the Board recommends a suitable mode of transportation that is safe, expedient, practical and cost effective.

Where the Board considers that the worker's choice of transportation would put the worker's safety at risk, the Board may consider the worker to be engaging in an unsanitary or injurious practice, and therefore reduce or suspend the worker's compensation, if the circumstances in Item C10-74.00 are met.

4. MANNER OF PAYMENT

Whenever possible, the Board schedules and pays for transportation directly. A worker may be required to reimburse the Board for the amounts paid directly if:

(a) the worker either does not attend, or does not attend in part, the health care in respect of which the transportation was paid or does not use the pre-arranged mode of transportation; and

(b) the amounts paid directly cannot be refunded or transferred to be used at another time.

In these cases, the worker may also be required to reimburse the Board for additional costs, and any change or cancellation fees associated with the transportation if the Board determines:

(a) there is no reasonable explanation that would justify the worker's actions, such as unexpected illness or compelling personal reasons (e.g. a death in the family); or

(b) the change or cancellation was due to the worker's personal choice or preference, not related to the worker's compensable or non-compensable disability.

If it is not possible for the Board to schedule transportation directly or if mileage is paid, the Board may pay a transportation allowance to the worker in advance of the travel for the expected transportation costs incurred, up to an amount the Board considers reasonable. A worker is required to reimburse the Board for the transportation allowance if:

(a) the worker either does not attend, or does not attend in part, the health care in respect of which the transportation allowance was paid; and

(b) the allowance cannot be applied towards the transportation at another time.

The Board may recover the amounts paid:

- for transportation booked directly,
- through the provision of a transportation allowance, and/or
- for change fees, cancellation fees, or additional costs.

The Board may recover the above amounts by treating them as an overpayment and deducting them from the worker's compensation, or the worker may reimburse the Board directly.

If direct booking or payment by way of a travel allowance is not possible, the worker generally pays transportation costs as they are incurred, and advises the Board of the amount paid. The Board then calculates the amount of transportation payable and reimburses the worker for that amount.

5. AMOUNT PAYABLE

If the worker chooses to take a mode of transportation other than the one recommended by the Board, the Board pays for the more cost effective option, which is usually bus

fare, together with transportation to and from the bus terminal. In this regard, the Board may establish a schedule of rates, adjusted periodically. Otherwise, the following sections set out how the Board determines how much it will pay for transportation for a worker's receipt of health care.

5.1 Travel by Air

Where the Board considers travel by air to be the most appropriate mode of transportation for the worker, the Board pays for transportation equal to the cost of the airfare, together with the cost of transportation to and from airports.

5.2 Travel by Public Transportation

Where the Board considers travel by public transportation to be the most appropriate mode of local transportation for the worker, the Board pays for transportation equal to the actual cost of the public transportation.

Generally, the Board considers travel by public transportation the most appropriate mode of local transportation where it is available and is a reasonable means of travel for the journey to be made by the worker.

5.3 Travel by Private Vehicle

Where the Board considers travel by private vehicle to be the most appropriate mode of transportation for the worker, the Board pays for transportation based on mileage at the rate set out below:

Date	Amount Per Kilometre
January 1, 2025 – December 31, 2025	72¢
January 1, 2026 – December 31, 2026	73¢

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

The Board adjusts the mileage rate annually on January 1st of each year to the maximum tax-exempt mileage allowance as determined by the Canada Revenue Agency for British Columbia, as prescribed by section 7306 of the Canadian *Income Tax Regulations*.

5.4 Travel by Taxi

Where the Board considers travel by taxi to be the most appropriate mode of transportation for the worker, the Board pays a transportation amount equal to the actual cost of taxi fares. The Board may consider travel by taxi reasonably necessary where, given the nature and extent of the worker's compensable or pre-existing personal injury, occupational disease or mental disorder:

(a) no other mode of transportation is appropriate for local travel; or

(b) when travelling to a distant centre for health care, the worker:

(i) requires transportation from the worker's residence to or from an airport or commercial bus or ferry terminal; or

(ii) requires transportation while at the distant centre, for example, between health care facilities or between a health care facility and the worker's place of accommodation.

5.5 Parking and Toll Fees

Regardless of whether the Board pays for mileage, the Board pays reasonable parking charges and toll fees the worker incurs while attending a health care facility, or in connection with travel to or from a health care facility (including, for example, parking charges at an airport, ferry terminal or bus terminal). The Board does not pay for parking violations.

EFFECTIVE DATE:	September 1, 2022
AUTHORITY:	Sections 156, 159, and 160 of the *Act*.
CROSS REFERENCES:	Item C7-48.10, *Overpayments/Money Owed to the Board*; Item C7-51.00, *Cost of Living Adjustments to Periodic Payments*; Item C10-73.00, *Direction, Supervision, and Control of Health Care*; Item C10-83.10, *Subsistence Allowances*; Item C11-88.00, *Vocational Rehabilitation – Nature and Extent of Programs and Services*; Item C11-88.90, *Vocational Rehabilitation – Relocation*; Item C12-100.10, *Reimbursement of Expenses*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 − Housekeeping change to update internal cross-reference, consequential to reformatting and renumbering Chapter 12, *Claims Procedures.* September 1, 2022 − Mileage rate increased and tied to maximum tax-exempt mileage allowance of the Canada Revenue Agency. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

January 1, 2015 − This policy incorporated the concepts from and replaced former policy items #82.00, #82.10, #82.11, #82.20, #82.30 and #82.50 of the *Rehabilitation Services & Claims Manual*, Volume II.
June 1, 2009 – Deleted references to Board officer, Review Division, and Board officer in Vocational Rehabilitation Services.
March 3, 2003 – Inserted references to the Review Division, the Workers' Compensation Appeal Tribunal and section 7 of the *Workers Compensation Act Appeal Regulation.*

APPLICATION: This Item applies to health care expenses incurred and health care provided on or after September 1, 2022.

RE: Subsistence Allowances **ITEM: C10-83.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on when the Board pays subsistence allowances as a health care benefit.

2. The Act

Section 1, in part:

> **"dependant"**
>
> (a) means
>
> (i) a family member of the worker who was wholly or partly dependent on the worker's earnings at the time of the worker's death, or
>
> (ii) a family member of the worker who, but for the worker's incapacity due to the accident or occupational disease, would have been wholly or partly dependent on the worker's earnings,…
>
> ...
>
> **"family member"**, in relation to a worker, means the following:
>
> (a) a spouse, parent, grandparent, step-parent, child, grandchild, stepchild, sibling or half-sibling of the worker;
>
> (b) a person, whether related to the worker by blood or not, who stood in place of a parent of the worker or to whom the worker stood in place of a parent;
>
> ...

Section 134(4):

> See Item C10-72.00.

Section 156:

See Item C10-72.00.

Section 202:

(1) This section applies to a worker who receives

(a) a periodic payment of compensation under section 194(1), 195(1) or 196(1) *[compensation for permanent disability]* in respect of an injury, and

(b) a disability benefit under the *Canada Pension Plan* in respect of the injury.

(2) Subject to sections 194(2), 195(2) and 198(5) *[minimum compensation payments]*, the Board must deduct from a periodic payment referred to in subsection (1)(a), an amount that equals 50% of any disability benefit as referred to in subsection (1)(b).

Section 233:

(1) In setting the amount of a periodic payment of compensation to a worker, the Board must consider payments, allowances or benefits that the worker may receive from the worker's employer during the period of the worker's disability, including a pension, gratuity or other allowance provided wholly at the expense of the employer.

(2) An amount deducted under this section from the compensation otherwise payable to a worker may be paid to the worker's employer out of the accident fund.

POLICY

1. DEFINITIONS

"Subsistence" generally refers to the means for supporting the basic necessities of life; such as, accommodation, meals, income loss and dependant care.

As set out in Item C10-72.00, "residence" means the place where a worker lives or regularly stays. Where the worker has more than one residence, the worker is required to identify one as the primary residence.

2. OVERVIEW

The following sections provide guidance on when the Board pays a subsistence allowance for accommodation, meals, income loss and/or dependant care required as a result of a worker's attendance at a Board-approved health care appointment or program.

Where a worker is required to attend a vocational rehabilitation appointment, other than as part of a vocational rehabilitation plan, the Board pays subsistence allowances in the same manner and at the same rates as set out in this policy. Where a worker is participating in a vocational rehabilitation plan, the Board may establish the amount paid for subsistence separately as part of that plan.

3. ACCOMMODATION

3.1 Eligibility

Where a worker is required to spend one or more nights away from the worker's residence to obtain Board-approved health care for a compensable personal injury, occupational disease or mental disorder, the Board may pay a subsistence allowance to cover the cost of accommodation.

In determining whether a worker is required to stay away from the worker's residence for one or more nights, the Board considers a number of factors, including:

- the travel times and distance associated with roundtrip travel, as impacted by carrier schedules (e.g., flight, bus, ferry);
- the anticipated duration of the health care appointment or the health care program;
- the timing of the health care appointment or the health care program (e.g. early or late in the day, or over multiple days);
- the worker's transportation and accommodation preferences;
- the impact of travel on the worker's compensable disability;
- any potential safety issues with the travel and accommodation;
- any pre-existing medical and/or psychological conditions;
- the expected weather and road conditions during the proposed period of travel; and

- the cost effectiveness of roundtrip travel as compared to the cost of subsistence associated with an overnight stay.

3.2 Amounts Payable

Whenever possible, the Board schedules and pays for accommodation directly. If it is not possible for the Board to schedule accommodation directly, the Board pays the worker a subsistence allowance for the actual accommodation costs incurred, up to an amount that the Board considers reasonable.

The Board may recommend a particular accommodation based on:

- the nature of the worker's medical condition;
- the medical opinion or other expert professional advice it receives;
- any contracts the Board has entered into with accommodation providers; and
- the proximity of the recommended accommodation to the health care appointment.

If the worker wishes to stay elsewhere, the Board pays a subsistence allowance equal to the most cost effective option. Where the worker wishes to stay with a friend or family member, the Board does not pay a subsistence allowance for accommodation. In all cases where a worker chooses to stay somewhere other than the recommended option, any additional transportation costs are paid for by the worker.

Where the Board considers that the worker's choice or location of accommodation would put the worker's safety at risk, the Board may consider the worker to be engaging in an unsanitary or injurious practice, and therefore reduce or suspend the worker's compensation, if the circumstances in Item C10-74.00 are met.

Where accommodation is included in the amount the Board pays for a health care program, the Board does not pay any additional subsistence allowance for accommodation.

4. MEALS

4.1 Eligibility

The Board may pay a subsistence allowance to cover the cost of meals where, in connection with attendance at a Board-approved health care appointment or program, the worker:

- travels by air; or
- is required to be away from the worker's residence for 10 hours or more.

In these cases, the Board may pay a subsistence allowance to cover the cost of those meals missed due to the worker being away from the worker's residence over the entire meal period(s).

For the purposes of this policy, meal periods are defined as follows:

Meal	Time Period
Breakfast	6:30 to 8 am
Lunch	12 to 1 pm
Dinner	5 to 6:30 pm

If a worker is eligible for payment for transportation to visit the worker's residence while participating in a Board-approved health care program, the worker may also be eligible for a subsistence allowance for meals during the course of travel to and from the worker's residence.

The Board only pays the subsistence allowance for meals during the course of travel if the worker chooses the Board's recommended mode of transportation. For example, if the Board recommends air travel, but the worker chooses to drive, the Board pays the subsistence allowance for meals based on the meal periods that would have been missed had the worker travelled by air.

4.2 Amounts Payable

Where the eligibility requirements are met, the Board pays a subsistence allowance for meals with reference to the full or partial per diem meal allowance rates set out below:

Date	Breakfast	Lunch	Dinner	Per Day
January 1, 2025 – December 31, 2025	$16.27	$20.09	$34.54	$70.90
January 1, 2026 – December 31, 2026	$16.62	$20.52	$35.29	$72.43

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

Effective June 30, 2002, the Board adjusts the meal allowance rates annually on January 1st of each year using the percentage change in the consumer price index for Canada.

Where meals are included in the amount the Board pays to a health care facility, the Board does not pay any additional subsistence allowances for meals.

5. INCOME LOSS

5.1 Eligibility

Where a worker who is not disabled from working loses time from work to attend Board-approved health care, and thereby incurs a loss of income, the Board may pay a subsistence allowance to compensate the worker for that income loss. These situations involve either:

- a worker who has never been declared disabled as the result of a compensable personal injury, occupational disease or mental disorder; or
- a worker who has returned to work following a period of compensable disability, but is still undergoing Board-approved health care.

When evaluating whether to pay a subsistence allowance for income loss and how much to pay, the Board takes into account whether the income loss is due to the worker's personal choice of health care provider. If it involves bypassing a closer health care provider whom the Board considers adequate, the Board may not pay any, or as much, subsistence allowance for income loss.

The Board pays a subsistence allowance for income loss where the Board determines it is unreasonable for the worker to attend health care outside of work hours. Generally, the Board does not pay a subsistence allowance for income loss if the time loss incurred is under two hours; however, the Board may pay a subsistence allowance for income loss if the worker's aggregate time loss resulting from multiple appointments results in a significant income loss.

While these payments are not temporary disability wage-loss benefit payments, the Board applies the provisions of section 134(4) of the *Act*. As such, the Board does not pay a subsistence allowance for income loss for losses incurred on the day of the injury.

In situations where the worker is maintained on full salary by the employer and an entitlement to a subsistence allowance for income loss has arisen, the Board may pay the subsistence allowance for income loss to the employer under the terms of section 233(2) of the *Act*.

5.2 Amounts Payable

A subsistence allowance for income loss is equal to 90% of the worker's average net earnings for the time lost. However, it is subject to the same maximum and minimum rules that are applicable to temporary total disability wage-loss benefits.

6. TEMPORARY DEPENDANT CARE DURING PERIOD OF DISABILITY

6.1 Eligibility

The Board may cover the cost of temporary dependant care during a period of disability if the Board determines that:

(a) the costs are incurred by a worker as a result of the worker's compensable personal injury, occupational disease or mental disorder;

(b) the costs are over and above dependant care costs the worker normally incurred prior to the compensable personal injury, occupational disease or mental disorder; and

(c) no other suitable arrangements can be made with family, friends, or through the use of community resources.

The types of situations where the Board may pay a subsistence allowance on a temporary basis to cover dependant care costs include, but are not limited to, situations where:

(a) the worker requires emergency treatment and must be immediately transported to a health care facility, thereby leaving dependants unattended;

(b) the worker is required to attend Board-approved health care; or

(c) the severity of the disability resulting from the worker's compensable personal injury, occupational disease or mental disorder temporarily prevents the worker from being able to personally provide dependant care.

6.2 Amounts Payable

The Board pays a reasonable amount for dependant care as a subsistence allowance to eligible workers where the costs exceed the costs the worker normally incurred prior to the compensable personal injury, occupational disease or mental disorder.

The Board pays the additional new costs above any amount the worker paid prior to the compensable personal injury, occupational disease or mental disorder. The Board does

not pay additional costs that arise due to factors unrelated to the compensable personal injury, occupational disease or mental disorder.

When determining the amount to be paid, the Board considers reasonable community rates for the services provided and provincial government rates for dependant care subsidies.

EFFECTIVE DATE:	January 1, 2015
AUTHORITY:	Sections 1, 134, 156, 202, 233, and 334 of the *Act*.
CROSS REFERENCES:	Item C5-33.10, *Wage-Loss Benefits For Temporary Total Disability*; Item C5-34.10, *Payment of Wage-Loss Benefits;* Item C7-51.00, *Cost of Living Adjustments to Periodic Payments;* Item C9-68.00, *Composition of Average Earnings*; Item C9-69.00, *Maximum Amount of Average Earnings*; Item C10-84.00*, Additional Benefits for Severely Injured Workers*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. January 1, 2015 − This policy incorporated the concepts from and replaced former policy items #83.00, #83.10, #83.13, #83.20, #84.20 and #84A.00 of the *Rehabilitation Services & Claims Manual*, Volume II. June 1, 2009 − Deleted references to Board officer, Rehabilitation Centre, Vocational Rehabilitation Services and Board officer in Vocational Rehabilitation Services.
APPLICATION:	This Item applies to health care expenses incurred and health care provided on or after January 1, 2015.

RE: Travelling Companions and Visitors **ITEM: C10-83.20**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on when the Board pays transportation and/or subsistence allowances for travelling companions and visitors as a health care benefit.

2. The Act

Section 1, in part:

> **"family member"**, in relation to a worker, means the following:
>
> (a) a spouse, parent, grandparent, step-parent, child, grandchild, stepchild, sibling or half-sibling of the worker;
>
> (b) a person, whether related to the worker by blood or not, who stood in place of a parent of the worker or to whom the worker stood in place of a parent;
>
> ...

Section 156:

> See Item C10-72.00.

POLICY

1. ELIGIBILITY

1.1 Travelling Companions

A "travelling companion" is a family member or other person with a close personal attachment to a worker who accompanies a worker on Board-approved travel.

The Board may pay for transportation and/or a subsistence allowance for meals and accommodation for a travelling companion. In making this determination, the Board considers factors such as whether:

(a) it is medically necessary for a travelling companion to accompany the worker (for example, based on the nature of the compensable condition

and/or the type of health care to be received, the Board determines a travelling companion is necessary);

(b) the travelling companion is required due to legal reasons (for example, the worker is a minor and parental consent is required to treat the worker); and/or

(c) the travelling companion is reasonably necessary for any other situation.

The Board does not pay wage-loss compensation or subsistence allowances for income loss or temporary dependant care for travelling companions.

1.2 Visitors

A "visitor" is a family member or other person with a close personal attachment to a worker, who visits a worker while the worker is receiving Board-approved health care.

The Board may pay for transportation and/or a subsistence allowance for meals and accommodation for a visitor to visit the worker while the worker is receiving health care in a health care facility away from the worker's resident community where:

- a worker is participating in a Board-approved health care program that requires the worker to live elsewhere than the worker's residence for a period of six weeks or more. In this case, in lieu of paying for transportation and/or a subsistence allowance in respect of a visit home, the Board may pay for transportation and/or a subsistence allowance for a visitor to visit the worker for up to two nights, once every three weeks; or

- the Board determines that a visitor is reasonably necessary (for example, due to legal reasons).

The Board does not pay wage-loss compensation or subsistence allowances for income loss or temporary dependant care for visitors.

2. DURATION

The Board generally pays a subsistence allowance for accommodation for a travelling companion for one night, where the Board determines that it is not reasonable for the travelling companion to return home on the same day that the travelling companion accompanies the worker for the Board-approved health care. The Board may pay a subsistence allowance for accommodation to a travelling companion for a longer period to accompany the worker home, where the Board determines that it is medically necessary for a travelling companion to accompany the worker.

The Board may pay a subsistence allowance for accommodation for a visitor for one night. The Board may, where it is considered reasonably necessary, pay for a longer period in individual cases.

3. AMOUNTS PAYABLE

The Board determines the amount of transportation costs and subsistence allowances to pay for travelling companions and visitors in the same manner as it does for workers, as set out in Items C10-83.00 and C10-83.10.

EFFECTIVE DATE:	January 1, 2015
AUTHORITY:	Sections 1 and 156 of the *Act*.
CROSS REFERENCES:	Item C10-83.00, *Transportation*; Item C10-83.10, *Subsistence Allowances*; Item C12-97.30, *Medical Evidence*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	October 21, 2020 – Housekeeping amendments to the *Act* portion of the Background section. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. January 1, 2015 − This policy incorporated concepts from and replaced former policy items #83.11 and #83.12 of the *Rehabilitation Services & Claims Manual*, Volume II. June 1, 2009 – Deleted references to Board officer, Rehabilitation and Compensation Services Division and Compensation Services Division.
APPLICATION:	This Item applies to health care expenses incurred and health care provided on or after January 1, 2015.

RE: Date of Injury Transportation **ITEM: C10-83.30**

BACKGROUND

1. Explanatory Notes

This policy sets out the circumstances in which employers are responsible for costs associated with the immediate conveyance and transportation of a worker to a hospital, physician or qualified practitioner for initial treatment.

2. The Act

Section 159(2):

> See Item C10-83.00.

3. *Workers Compensation Act*, Fishing Industry Regulations

Section 13:

> For the purposes of section 159 *[employer authority and obligations in relation to health care]* of the Act, the expense of transporting an injured fisher to a hospital, physician or other qualified practitioner for initial treatment must be paid by the owner of the vessel on which the fisher is injured or where the vessel is chartered by the charterer of the vessel on which the fisher is injured or in default of payment by the vessel owner or charterer the vessel master.

POLICY

An employer's obligation to provide an injured worker with immediate conveyance and transportation arises whether the work injury occurs on the employer's premises, at another worksite or wherever the need for initial treatment arises, when the worker is injured in the course of the worker's employment.

Immediate conveyance and transportation for initial treatment is necessary whenever there is a sense that the worker requires immediate or urgent treatment from a hospital, physician or qualified practitioner.

The employer's cost of immediate conveyance and transportation may include the cost of medical equipment required to transport the worker to a health care facility.

In the event that a physician or qualified practitioner travels to the worker to provide initial treatment, the employer is responsible for any charge with respect to transportation.

EFFECTIVE DATE:	January 1, 2015
AUTHORITY:	Section 159 of the *Act*; Section 13 of the *Fishing Industry Regulations*, B.C. Reg. 674/76.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. January 1, 2015 − This policy replaced former policy item #82.40 of the *Rehabilitation Services & Claims Manual*, Volume II. Former policy item #82.40 was amended effective March 18, 2003 to remove the reference to *Workers' Compensation Reporter* Decision No. 223, re: *The Fishing Industry*, as a consequential amendment of the Decision's retirement from policy status, which came into effect on January 1, 2003. March 18, 2003 – Deleted reference to the *Workers' Compensation Reporter* Decision No. 223.
APPLICATION:	This Item applies to health care expenses incurred and health care provided on or after January 1, 2015.

RE:	Additional Benefits for Severely Disabled Workers	ITEM:	C10-84.00

BACKGROUND

1. Explanatory Notes

This policy sets out the additional benefits that may be available to severely disabled workers.

2. The Act

Section 155, in part:

> (1) To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.
>
> ...
>
> (3) The Board may, if it considers this advisable, provide counselling and placement services to dependants of a worker.

Section 156:

> See Item C10-72.00.

Section 157:

> See Item C10-73.00.

Section 162:

> (1) If a worker has a permanent total disability, the Board must, within the 3-month period before a retirement benefit under section 206 *[retirement benefit for workers with permanent disability]* is payable to the worker, evaluate the worker's need or continued need for services and personal supports under this Division [Division 4 of Part 4 of the *Act* – Vocational Rehabilitation, Health Care and Other Assistance].

(2) After the evaluation under subsection (1) is completed, the Board must take all actions necessary to provide to the worker, for the worker's life, the services and personal supports under this Division that the Board considers necessary.

(3) This section does not limit the powers of the Board to otherwise provide services and personal supports to workers at any time under this Division.

POLICY

1. DEFINITIONS

The following terms are used throughout this policy.

As set out in Item C10-72.00, "activities of daily living" are basic activities that are performed by individuals on a daily basis for self-care. Examples include, but are not limited to: ambulating (e.g. walking), transferring (e.g. getting from bed to chair and back), feeding, dressing, personal hygiene (e.g. bathing, grooming, bladder and bowel care), and taking medication.

An "informal caregiver" is a family member or friend who assists a severely disabled worker at home with the worker's care and activities of daily living.

As set out in Item C10-72.00, "instrumental activities of daily living" are activities related to independent living. Examples include, but are not limited to: using a telephone, preparing meals, performing housework, shopping for groceries or personal items, managing medication, managing money, using public transportation, and maintaining and/or driving a car.

2. OBJECTIVE

The Board may pay for various additional health care benefits and vocational rehabilitation benefits and services to severely disabled workers. These are designed to alleviate the effects of the compensable personal injury, occupational disease or mental disorder and to assist in achieving physical, psychological, economic, social and vocational rehabilitation. The Board's goal is to assist severely disabled workers to reintegrate into the workplace, community and/or family environment.

3. ELIGIBILITY

For the purposes of this policy, a worker is considered to be a severely disabled worker if the worker has a work-related permanent disability that severely impacts mobility or function. The Board measures the level of disability by using the method of assessment

under section 195(1) of the *Act.* As a general rule, the level of disability will be equal to or greater than 75% of total disability.

The Board may provide additional benefits and services to severely disabled workers at its discretion, and determines the worker's eligibility based on the merits of each case. The Board may review and adjust the worker's entitlement for these benefits and services:

- on a periodic basis; and
- when the Board determines that the nature and extent of the worker's circumstances or disability warrant a change in benefits.

In assessing a worker's eligibility for a specific benefit or service under this policy, the Board may consider:

- the type, severity and duration of the worker's disability;
- up-to-date scientific evidence and evidence-based guidelines of professional health organizations on the effectiveness of the proposed benefit or service;
- medical opinion or other expert professional advice from Board-approved health care providers;
- standards developed by the Board to ensure quality health care is provided to workers;
- the financial implications of the proposed benefit or service; and
- alternative benefits or services that may be considered more appropriate to address the impact of the worker's compensable disability or functional needs.

This list is by no means exhaustive, and relevant factors not listed in policy may also be considered.

Where a worker has a work-related severe temporary disability, or a work-related permanent disability of less than 75% total disability, the Board may consider entitlement to one or more benefits or services set out in this policy, in situations such as if:

- the worker has a pre-existing compensable or non-compensable condition that, when combined with the compensable disability, severely impacts the worker's mobility and function;

- the compensable disability severely impacts the worker's mobility and function and the worker, due to the worker's personal or family situation, is unable to obtain assistance from an informal caregiver; or

- the compensable disability severely impacts the worker's mobility and function and the worker is not within geographical proximity to community health care services.

4. ADDITIONAL BENEFITS AND SERVICES FOR SEVERELY DISABLED WORKERS

Set out in the following sections are additional benefits and services that may be available to severely disabled workers.

4.1 Personal Care Expenses and Allowances

The Board takes the steps that it deems appropriate in order to assist severely disabled workers with their activities of daily living. The Board normally does this by paying actual personal care expenses or flat-rate personal care allowances.

4.1.1 Personal Care Expenses

The Board may pay personal care expenses when a severely disabled worker requires extensive or specialized personal care to assist with the worker's activities of daily living. The personal care in these situations is provided by a person who is employed with an agency or facility registered to provide health care services to a severely disabled worker. Based on the level of assistance needed by the worker, the personal care may be provided in a health care facility or in the worker's home.

The Board pays the worker's actual personal care expenses directly to the facility or agency providing the care.

4.1.2 Personal Care Allowances

The Board may pay a flat-rate personal care allowance where a worker requires assistance with activities of daily living, which may be provided by an informal caregiver. The Board pays the worker's personal care allowance directly to the worker, not to the informal caregiver. The Board may supplement a personal care allowance by paying some personal care expenses where a worker needs additional personal care.

The Board suspends payment of the personal care allowance if a worker, who is in receipt of the allowance, requires care in a health care facility for more than 14 consecutive calendar days. The Board reinstates payment of the personal care allowance when the worker returns home and the informal caregiver resumes providing the worker's care.

4.1.3 Categories of Personal Care Allowances

There are five categories of disability for which the Board considers paying personal care allowances:

Category 1: The worker requires minimal assistance with activities of daily living. For example, the worker has restricted mobility and needs some assistance with transferring, and/or requires some daily supervision to perform activities of daily living due to cognitive impairment and/or safety issues caused by the compensable disability. The worker, however, can feed, groom and clothe themselves.

Examples of compensable disabilities that might entitle a worker to a Category 1 personal care allowance include, but are not limited to:

- moderate brain injury,
- blindness or near blindness,
- multiple amputations at the wrist or ankle,
- aphasia, and
- hemiplegia.

Category 2: The worker has restricted mobility and requires assistance with regard to bowel or bladder malfunction. The worker can feed, clothe and wash themselves but needs assistance in other aspects of personal care and activities of daily living.

An example of a compensable disability that might entitle a worker to a Category 2 personal care allowance is paraplegia with bowel and bladder functions impaired.

Category 3: The worker requires moderate assistance with activities of daily living. The worker requires assistance with feeding, cleansing, grooming, and dressing.

Examples of compensable disabilities that might entitle a worker to a Category 3 personal care allowance include, but are not limited to:

- severe head injury resulting in brain damage to the extent that the worker is not bedridden, but is dependent upon assistance and ongoing care; and
- quadriplegia.

Category 4: The worker is almost totally immobile and requires extensive assistance in all activities of daily living.

Examples of compensable disabilities that might entitle a worker to a Category 4 personal care allowance include, but are not limited to:

- high lesion quadriplegia; and
- severe head injuries.

Category 5: The worker is totally immobile and requires extensive assistance in all activities of daily living.

Examples of disabilities that might entitle a worker to a Category 5 personal care allowance include, but are not limited to:

- high lesion quadriplegia with ventilator dependency;
- disabilities requiring palliative care in the home;
- severe head injuries that require constant attendance and care; and
- a combination of quadriplegia and head injury.

4.1.4 Personal Care Allowance Payable at Each Category

The Board pays each category of personal care allowance as set out below:

	Category 1	Category 2	Category 3	Category 4	Category 5
January 1, 2025 – December 31, 2025					
Daily Amount	$21.86	$37.26	$55.42	$71.76	$88.49
Monthly Amount	$658.22	$1,151.53	$1,663.27	$2,156.59	$2,650.56
January 1, 2026 – December 31, 2026					
Daily Amount	$22.33	$38.07	$56.62	$73.31	$90.40
Monthly Amount	$672.46	$1,176.44	$1,699.25	$2,203.24	$2,707.90

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

Effective June 30, 2002, the Board adjusts personal care allowances annually on January 1st of each year, using the percentage change in the consumer price index for Canada.

4.2 Respite Care

Severely disabled workers in receipt of a personal care allowance may qualify for respite care.

“Respite care” is short-term, temporary care provided to a severely disabled worker to relieve the worker’s informal caregiver from providing the worker with care and assistance with the worker’s activities of daily living. Respite care is provided by an agency or in a facility registered to provide health care services to severely disabled workers.

The Board arranges for the respite care and makes payments directly to the agency or facility providing the care. The worker's personal care allowance is not suspended where the duration of the respite care is for a period of up to 14 consecutive days once each calendar year.

4.3 Major Home and Vehicle Modifications

In order to promote the mobility, accessibility, safety and self-sufficiency of severely disabled workers, the Board may provide major home and vehicle modifications as discussed below. When providing major home and vehicle modifications to severely disabled workers, the Board also applies the policy in Item C10-81.00.

Direction by the Board and/or prior Board approval is required for any home or vehicle modifications, and any unauthorized modifications or upgrades may be at the worker's own expense.

Set out in the following sub-sections are details of the types of major modifications that may be available to severely disabled workers.

4.3.1 Major Home Modifications

Major home modifications may include, but are not limited to the following:

- kitchen and bathroom renovations;
- widening doorways to accommodate a wheelchair; or
- purchasing and installing equipment such as an elevator, stair glide or other lift device.

Major home modifications that the Board does not provide include, but are not limited to, building recreational areas, workshops or exercise rooms.

The Board pays for major home modifications:

- on the worker's primary residence; and
- on a one-time only basis.

The Board may make exceptions according to the worker's individual circumstances.

The worker is responsible for any repair and/or maintenance costs of major home modifications that result from deliberate misuse or abuse by the worker.

If the Board determines that the worker's current home is not structurally suitable for major modification, the Board may contribute an amount of money towards the cost of purchasing a more accessible home. The Board's contribution is an amount up to but not exceeding the actual cost of approved modifications to the worker's current home. This decision does not prohibit the Board from then modifying the new home. The Board makes a separate decision regarding entitlement to modifications to the new home.

4.3.2 Major Vehicle Modifications

Major vehicle modifications may include, but are not limited to, such things as providing wheelchair access to a vehicle by installing a van lift or power door opener, or converting a manual vehicle to an automatic.

Where the Board determines that the worker does not own a vehicle that is appropriate for the required modification or if it would be more cost effective to purchase a vehicle, the Board may enter into an agreement with the worker regarding purchase of a vehicle that is more appropriate for the required modification. In these cases, the worker would contribute the value of their current vehicle and the Board would contribute an amount up to but not exceeding the difference between the worker's contribution and the cost of the new vehicle.

Major vehicle modifications that the Board does not pay for include, but are not limited to, optional upgrades that the Board does not consider reasonably necessary to alleviate the effects of the compensable personal injury or occupational disease.

The Board generally only pays for major vehicle modifications when the worker is licensed, qualified to drive, and owns, rather than leases, the vehicle. This may include situations where the worker was licensed and owned a vehicle but, due to the nature and extent of the worker's compensable disability, the worker is now transported in the vehicle by another licensed driver.

The Board may pay for subsequent major vehicle modifications based on the Board's assessment of the worker's need for the vehicle modification. In making this determination, the Board considers the factors regarding the appropriateness of a vehicle modification as set out in Item C10-81.00. The Board only pays for major vehicle modifications to one vehicle at a time.

The Board pays for the repair and replacement of major vehicle modifications paid for by the Board when there is a demonstrated deficiency or deterioration in the modification so that it no longer meets the worker's needs, cannot be cost effectively repaired, or jeopardizes the worker's or others' safety.

The worker is responsible for any repair and/or maintenance costs of major vehicle modifications that result from deliberate misuse or abuse by the worker.

When the vehicle is no longer roadworthy, but the modification is still in good working order, the Board may pay the costs associated with moving the modification to a new vehicle. The Board determines whether to contribute an amount toward the purchase of the new vehicle in accordance with the following section.

4.4 Vehicle Purchase

The Board may purchase or replace a vehicle for a worker where the worker does not own a vehicle that is appropriate for modification and:

- is only able to use a power wheelchair;
- uses a manual wheelchair, but medical evidence indicates that the worker, due to an injury with upper-limb involvement or other causes resulting in a similar level of functioning, is unable to self-transfer from the wheelchair into the vehicle; or
- is a severely brain-injured worker with a level of disability equivalent to the level of function of a worker with an upper-limb involvement injury.

The Board determines the type of vehicle to purchase based on the worker's level of function.

A new vehicle is generally expected to remain roadworthy for at least 10 years. If the worker requests a new vehicle before 10 years on the basis that the current one is not roadworthy, the Board evaluates the request on a case-by-case basis.

The Board only pays to replace a worker's vehicle if there is a demonstrated deficiency or deterioration in the vehicle so that it no longer meets the worker's needs, cannot be cost-effectively repaired, and/or jeopardizes the worker's or others' safety. Exceptional circumstances are considered (for example, manufacturer's defects, mileage, etc.). If the worker cannot produce regular maintenance records, the Board may pro-rate the replacement vehicle costs between the worker and the Board. In those cases where the Board pays for a replacement vehicle, the Board may take responsibility for disposal of the existing vehicle.

The worker is responsible for:

- the cost of general maintenance and repair expenses for Board-purchased vehicles, such as oil changes and emission testing, as these types of expenses would be incurred by any vehicle owner; and
- ensuring that the Board-purchased vehicle is appropriately insured for both basic and any necessary optional coverage. The Board does not pay these insurance premiums.

The Board sets these and other terms and conditions at the time the vehicle is purchased for the worker.

The Board may pay for the maintenance and/or repair of vehicle modifications made to the Board-purchased vehicle, which are specifically required due to the worker's compensable personal injury or occupational disease.

The worker is responsible for any repair and/or maintenance costs of vehicle modifications made to the Board-purchased vehicle that result from deliberate misuse or abuse by the worker.

4.5 Independence and Home Maintenance Allowance

In order to assist severely disabled workers with their instrumental activities of daily living and maintaining their primary residence, the Board may pay an independence and home maintenance allowance, over and above any personal care allowance or expenses, temporary disability wage-loss benefits, or permanent disability benefits.

This allowance is intended for services or items such as, but not limited to, the following:

- assistance with shopping for groceries or personal items;
- housecleaning services;
- using a taxi service where the worker is unable to maintain/drive a personal vehicle or take public transportation;
- gutter cleaning;
- tradespersons to perform general home maintenance or repairs;
- snow-removal or lawn and yard maintenance service; and
- delivery of wood to wood-heated homes.

In determining whether to provide an independence and home maintenance allowance, the Board considers the following:

- whether the worker has demonstrated an inability to perform instrumental activities of daily living due to the compensable disability and therefore requires assistance with those tasks;
- whether the worker has demonstrated an inability to perform home maintenance activities that most other workers would have the physical capacity to do on their own; and

- whether the worker lives in and maintains the worker's primary residence.

A worker who does not live in and/or maintain a primary residence, but owns another form of accommodation may be eligible for the allowance if the Board determines that the worker would have contributed to its maintenance had the disability not occurred.

In addition, a worker who lives in a health care facility, but whose spouse and/or child(ren) continue to live in the family home, may be eligible for the allowance if the Board determines that the spouse and/or child(ren) are responsible for the maintenance activities covered by the allowance.

Where the worker has a pre-existing disability that is non-compensable, the compensable disability must be at least half the worker's combined total disability, and be a significant factor in the worker's inability to do the activities covered by the allowance.

A worker's eligibility for the independence and home maintenance allowance commences as of the date the Board determines the worker has an inability to perform instrumental activities of daily living and/or perform home maintenance activities that most other workers would have the physical capacity to do on their own. This includes the date the worker begins living in a health care facility where the worker's spouse and/or child(ren) continue to live in the family home.

A worker's eligibility for the independence and home maintenance allowance terminates upon the death of the worker, when the worker requires long-term care in a health care facility, or when the Board determines the worker is actually able to perform instrumental activities of daily living and/or the home maintenance activities that most other workers would have the physical capacity to do on their own.

If the worker lives in a health care facility and the Board is providing the home maintenance allowance for the spouse or child(ren) living in the family home, the Board stops paying the allowance at the earliest of:

- the spouse and/or child(ren) no longer living in the family home;
- the spouse and/or child(ren) living in the family home but no longer being responsible for the maintenance activities covered by the allowance; or
- the death of the worker.

The Board adjusts the independence and home maintenance allowance annually on January 1st of each year, using the percentage change in the consumer price index for Canada.

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

Date	Monthly Amount
January 1, 2025 – December 31, 2025	$385.56
January 1, 2026 – December 31, 2026	$393.90

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

4.6 Extensions of Health Care Treatments and Services for Severely Disabled Workers

The Board applies the policy in Items C10-76.00 and C10-77.00, in determining a severely disabled worker's general entitlement to the services of a physician, qualified practitioner or other recognized health care professional.

The Board may consider it reasonable to provide routine or long-term health care to severely disabled workers, based upon the nature and extent of their compensable personal injury or occupational disease. For example, the Board may pay for physiotherapy treatments beyond the limits set out in policy.

In extending the duration of health care, the Board considers the medical evidence that the health care will provide functional, preventative, or pain management benefits.

The Board may consider it reasonable to pay for treatment by more than one other recognized health care professional at a time (for example, treatment by a physiotherapist and a massage therapist), if both types of treatment are expected to lessen the impact of the worker's compensable personal injury or occupational disease.

4.7 Palliative Care Benefit

The Board, in consultation with the worker's physician, determines a worker's eligibility for a palliative care benefit. Generally the Board gives consideration to a worker for the palliative care benefit where the worker:

- has been diagnosed with a compensable injury or occupational disease;
- has a life expectancy of less than six months due to the compensable injury or occupational disease;
- is at or below 50% on the Palliative Performance Scale; and

- consents to the focus of care for the compensable injury or occupational disease being palliative rather than treatment aimed at cure.

Examples of items or treatments the Board may pay for as a palliative care benefit include, but are not limited to, homeopathic medicines, dietary supplements, non-prescription items and non-standard or experimental services. The Board provides these items or treatments at its discretion and pays the actual costs for them. When considering whether to pay for a specific item or treatment as a palliative care benefit, the Board gives consideration to whether the item or treatment:

- places the worker at greater risk than the effects of the compensable injury or occupational disease due to adverse side effects; and

- may be provided legally in Canada and is available from an accredited source.

EFFECTIVE DATE:	January 1, 2015
AUTHORITY:	Sections 155, 156, 157, and 162 of the *Act*.
CROSS REFERENCES:	Item C7-48.10, *Overpayments/Money Owed to the Board*; Item C7-49.00, *Incapacity of a Worker*; Item C7-51.00, *Cost of Living Adjustments to Periodic Payments*; Chapter 8 – Compensation on the Death of a Worker; Item C10-72.00, *Health Care – Introduction*; Item C10-76.00, *Physicians and Qualified Practitioners*; Item C10-77.00, *Other Recognized Health Care Professionals*; Item C10-79.00, *Health Care Supplies and Equipment*; Item C10-81.00, *Home and Vehicle Modifications*; Item C10-82.00, *Clothing Allowances*; Item C10-83.00, *Transportation*; Item C10-83.10, *Subsistence Allowances*; Item C10-83.20, *Traveling Companions and Visitors*; Chapter 11 – Vocational Rehabilitation, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	October 21, 2020 – Housekeeping amendments to ensure consistent terminology. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. January 1, 2015 – This policy consolidated and replaced former policy items #80.00, #80.10, #80.20, and #81.00, and incorporated concepts from former policy items #80.30 and #80.40 of the *Rehabilitation Services & Claims Manual*, Volume II.
APPLICATION:	This item applies to health care expenses incurred and health care provided on or after January 1, 2015.

RE:	Vocational Rehabilitation − Principles and Goals	ITEM:	C11-85.00

BACKGROUND

1. Explanatory Notes

This policy sets out the principles and goals of vocational rehabilitation.

2. The Act

Section 155:

(1) To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

(2) If compensation is payable under this Part [Part 4 of the *Act* – Compensation to Injured Workers] as the result of the death of a worker, the Board may make provisions and expenditures for the training or retraining of a dependent spouse, regardless of the date of death.

(3) The Board may, if it considers this advisable, provide counselling and placement services to dependants of a worker.

Section 162:

(1) If a worker has a permanent total disability, the Board must, within the 3-month period before a retirement benefit under section 206 *[retirement benefits for workers with permanent disability]* is payable to the worker, evaluate the worker's need or continued need for services and personal supports under this Division [Division 4 of Part 4 – Vocational Rehabilitation, Health Care and Other Assistance].

(2) After the evaluation under subsection (1) is completed, the Board must take all actions necessary to provide to the worker, for the worker's life, the services and personal supports under this Division that the Board considers necessary.

(3) This section does not limit the powers of the Board to otherwise provide services and personal supports to workers at any time under this Division.

POLICY

Quality Rehabilitation

The mission of the Board with respect to vocational rehabilitation services is to provide quality interventions and services to assist workers in achieving early and safe return to work and other appropriate rehabilitation outcomes. Quality rehabilitation requires individualized vocational assessment, planning, and support provided through timely intervention and collaborative relationships to maximize the effectiveness of rehabilitation resources and worker-employer outcomes.

The Board is committed to timely intervention to assist workers and employers in achieving successful return to work outcomes. The Board recognizes that early return to safe and durable work plays an important role in workers' recovery while helping maintain workers' dignity and productivity.

Principles of Vocational Rehabilitation

The guiding principles of quality vocational rehabilitation are:

1. Vocational rehabilitation should be initiated without delay and proceed in conjunction with medical treatment and physical rehabilitation to restore the worker's capabilities as soon as possible.

2. Reasonably necessary vocational rehabilitation assistance will be provided to overcome the immediate and long-term vocational impact of the compensable injury, occupational disease or fatality.

3. Successful vocational rehabilitation requires that workers be motivated to take an active interest and initiative in their own rehabilitation. Vocational programs and services should, therefore, be offered and sustained in direct response to the commitment and determination of workers to re-establish themselves.

4. Maximum success in vocational rehabilitation requires that different approaches be used in response to the unique needs of each individual.

5. Vocational rehabilitation is a collaborative process, which requires the involvement and commitment of all concerned participants.

6. Effective vocational rehabilitation recognizes, within reason, workers' personal preferences and their accountability for independent vocational choices and outcomes.

7. The gravity of the injury and residual disability is a relevant factor in determining the nature and extent of the vocational rehabilitation assistance provided. The Board should go to greater lengths in cases where the disability is serious than in cases where it is minor, including measures to assist workers to maintain useful and satisfying lives.

8. Where the worker has a compensable injury or disease together with some other impediment to returning to work, rehabilitation assistance may sometimes be needed and provided to address the combined problems. Rehabilitation assistance should not be initiated or continued when the primary obstacle to a return to work is non-compensable.

9. Vocational rehabilitation services should be provided in a cost-effective manner.

Goals

The objective of vocational programs and services is timely return to safe and durable work.

The goals of vocational rehabilitation are:

1. For workers with a temporary total disability, the goal is to assist injured workers in expediting recovery and return to work with the pre-injury employer. As these workers are considered unable to perform their pre-injury employment due to the disability, the goal is to assist a worker to return to work with the pre-injury employer in a suitable work arrangement.

2. For workers with a temporary partial disability, the goal is to assist injured workers in their efforts to return to work in a suitable occupation and maximize short-term earning capacity up to the pre-injury wage rate. This goal reflects the wording of section 192 of the *Act,* which refers to a consideration of what a worker is earning, or is capable of earning in a suitable occupation.

3. For workers entitled to permanent partial disability benefits, the goal is to assist injured workers in their efforts to return to work in a suitable occupation and maximize long-term earning capacity up to the pre-injury wage rate.

4. For workers entitled to permanent total disability benefits, the goal is to assist in improving quality of life and minimizing the impact of the disability.

5. For dependent spouses, the goal is to provide counselling and vocational assistance to overcome the impact of the fatality.

6. For other dependants of deceased workers, the goal is to provide counselling and placement services to overcome the impact of the fatality.

In all cases, the goal is to provide reassurances, encouragement and counselling to help those entitled to compensation to maintain a positive outlook and remain motivated toward future economic and social capability.

Services Provided

These goals are met by providing the following services to its clients:

- counselling;
- vocational assessment and planning;
- job readiness/skill development;
- placement assistance;
- residual employability assessment; and
- evaluation of a worker's need or continued need for rehabilitation and health care services and supports, where a worker's permanent total disability will continue past retirement age.

EFFECTIVE DATE:	January 1, 2024
AUTHORITY:	Sections 155 and 162 of the *Act*.
CROSS REFERENCES:	Sections 154.2, 154.3, 190, 191, 192, 194, 195, and 196 of the *Act*; Item C5-35.10, *Duty to Cooperate*; Item C5-35.20, *Duty to Maintain Employment*; Item C11-91.00, *Vocational Rehabilitation – Vocational Assistance for Dependent Spouses and Dependants of Deceased Workers*; Item C18-116.30, *Retirement Benefits – Retirement Services and Personal Supports*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	January 1, 2024 – Policy changes made consequential to implementing Division 3.1 of the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41). April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

February 1, 2020 – Policy amended to add statements related to VR principles and goals.
September 1, 2015 – Policy amended to ensure consistent treatment of workers with permanent partial disability compensation under sections 195 and 196 of the *Act.*
June 1, 2009 – Deleted references to Vocational Rehabilitation Services.
November 1, 2002 – Policy changed to set out the mission, principles and goals of Vocational Rehabilitation Services. Replaced policy items #85.00 to #85.60, of the *Rehabilitation Services & Claims Manual*, Volume II. Applies to decisions made on or after November 1, 2002 on claims adjudicated under the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as amended by the *Workers Compensation Amendment Act, 2002*.

APPLICATION: Applies to all decisions made on or after January 1, 2024.

RE:	Vocational Rehabilitation − Eligibility Criteria	ITEM:	C11-86.00

BACKGROUND

1. Explanatory Notes

This policy sets out eligibility criteria for vocational rehabilitation services.

2. The Act

Section 155(1):

> To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

Section 190:

> Compensation under this Division [Division 6 of Part 4 of the *Act* – Compensation for Worker Disability] is subject to the following provisions:
>
> (a) section 230 *[manner of compensation payment: periodic or lump sum]*;
>
> (b) section 231 *[payment of compensation in specific circumstances]*;
>
> (c) section 232 *[Board authority to discontinue or suspend payments]*;
>
> (d) section 233 *[deduction in relation to payments from employer]*.

Section 191(1), in part:

> … if a temporary total disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the worker's average net earnings.

Section 192(1), in part:

> … if a temporary partial disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the difference between
>
> (a) the worker's average net earnings before the injury, and
>
> (b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:
>
> (i) the average net earnings that the worker is earning after the injury;
>
> (ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury.

Section 194(1), in part:

> … if a permanent total disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the worker's average net earnings.

Section 195(1):

> Subject to section 196, if a permanent partial disability results from a worker's injury, the Board must
>
> (a) estimate the impairment of the worker's earning capacity from the nature and degree of the injury, and
>
> (b) pay the worker compensation that is a periodic payment of an amount that equals 90% of the Board's estimate of the worker's loss of average net earnings resulting from the impairment.

Section 196:

> (1) This section applies in relation to a permanent partial disability if an amount required under section 195 is less than an amount required under this section.
>
> (2) *Repealed*.
>
> (3) The Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the difference between

(a) the average net earnings of the worker before the injury, and

(b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:

(i) the average net earnings that the worker is earning after the injury;

(ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury.

POLICY

Eligibility

Rehabilitation assistance may be provided in cases where it appears to the Board that such assistance may be of value, and where a decision has been made that the injury, occupational disease or death is compensable.

Eligibility for vocational rehabilitation services will be determined in relation to the entitlement provisions of the *Act* as follows:

Temporary total disability

Vocational rehabilitation services are usually not provided to a worker with a temporary total disability, as the worker's medical condition often precludes the necessity of vocational rehabilitation initiatives. Limited vocational rehabilitation services may be considered where the Board determines that such services will assist in the worker's recovery and/or in making suitable work arrangements.

Temporary partial disability

Vocational rehabilitation services may be made available to a worker who is no longer considered to be "totally" disabled from working in the pre-injury occupation. The worker is considered capable of returning to a suitable occupation but may require vocational rehabilitation assistance to maximize short-term earning capacity up to the pre-injury wage rate.

Eligibility arises where:

- the compensable condition necessitates vocational rehabilitation assistance in early and safe return to work in the pre-injury occupation or another suitable occupation available over the short term;

- the compensable condition is complicated by non-compensable factors, the combination of which creates an impediment to return to work over the short term, necessitating assistance in an early and safe return to the pre-injury occupation or another suitable occupation;

- the pre-injury work is no longer available due to the injury and the worker requires assistance to return to work in another suitable occupation.

Permanent partial disability

Vocational rehabilitation services may be provided where a worker's temporary disability has ceased and the worker's medical condition has stabilized. Workers receiving permanent disability benefits are generally able to return to their pre-injury occupation or another suitable occupation but may need assistance in their return to the workforce.

Eligibility arises where:

- the compensable condition necessitates vocational rehabilitation to assist the worker in the worker's efforts to return to the pre-injury occupation;

- the compensable condition is complicated by non-compensable factors, the combination of which creates an impediment to return to work, necessitating assistance in the worker's efforts to return to the pre-injury occupation or another suitable occupation;

- the pre-injury work is no longer available due to the injury and the worker requires assistance to return to another suitable occupation; or

- the worker requires assistance in the worker's efforts to return to the workforce in another suitable occupation and maximize long-term earning capacity up to the pre-injury wage rate.

Permanent total disability

Vocational rehabilitation services will be provided to a worker with a permanent total disability where the worker needs assistance in improving the worker's quality of life. It may include evaluation of a worker's need or continued need for rehabilitation and health care services and supports, where a worker's permanent total disability will continue past retirement age.

Non-Compensable Problems

Where a worker has a compensable injury or disease together with some other impediment to a return to work (e.g. substance abuse), rehabilitation assistance may sometimes be needed and provided to address the combined problems.

Rehabilitation assistance should not be provided when the primary obstacle to a return to work is non-compensable.

Third-Party Claims

In the case of third-party claims, where a worker has a right of election, a worker is not eligible for rehabilitation assistance until the worker has elected to claim compensation with the Board.

Continuation of Assistance

In cases where the severity of an injury warrants immediate referral, intervention may precede the formal acceptance of the claim. Where this occurs, no substantial expenditures are initiated prior to acceptance of the claim. Should the claim be denied, any vocational rehabilitation assistance already being provided will terminate within 15 days unless a request for a review by the Review Division has been filed. In such cases, assistance may be continued pending disposition of the review.

Once a decision has been made that an injury or disease is compensable, there is no requirement that vocational rehabilitation assistance end at the same time payment of wage-loss benefits is concluded. The worker may no longer be eligible for wage-loss benefits, but vocational rehabilitation assistance may still be required and, where necessary, should be provided.

EFFECTIVE DATE:	January 1, 2024
AUTHORITY:	Sections 154.2, 154.3, 155, 190, 191, 192, 194, 195, 196, and 270(3) of the *Act*.
CROSS REFERENCES:	Item C5-35.10, *Duty to Cooperate*; Item C5-35.20, *Duty to Maintain Employment*; Item C11-86.10, *Vocational Rehabilitation − Referral Guidelines*; Item C16-111.10, *Third Party Claims – Injury Not Caused by Worker or Employer*; Item C18-116.30, *Retirement Benefits − Retirement Services and Personal Supports*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	January 1, 2024 − Policy changes made consequential to implementing Division 3.1 of the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41). December 1, 2023 – Housekeeping amendment. January 1, 2021 – Policy changes made consequential to implementing the permanent partial disability benefits provisions of the *Workers Compensation Amendment Act, 2020* (Bill 23). April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted reference to Board officer in Vocational Rehabilitation Services.

March 3, 2003 − The policy in this Item was amended to remove the reference to appeal and include a reference to review, consequential to the *Workers Compensation Amendment Act (No.2), 2002*.
November 1, 2002 − Replaces policy items #86.00, #86.20, #86.40 and #86.70 of the *Rehabilitation Services & Claims Manual*, Volume II.

APPLICATION: Applies to all decisions made on or after January 1, 2024.

RE:	Vocational Rehabilitation − Referral Guidelines	ITEM:	C11-86.10

BACKGROUND

1. Explanatory Notes

This policy sets out referral guidelines for vocational rehabilitation services.

2. The Act

Section 155(1):

> To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

POLICY

Referral Guidelines

The following guidelines are used in making referrals for vocational rehabilitation services. Internal Board referrals should clearly identify what has been accepted under the claim and specify reasons for the referral, including new information warranting repeat referral.

Workers may also be referred directly by physicians, hospitals, union representatives, employers and other agencies, or may seek assistance themselves.

Immediate Referrals

The following require immediate referral:

1. Spinal cord injuries resulting in paraplegia or quadriplegia.

2. Major extremity amputations or severe crush injuries.

3. Severe brain or brain stem injuries.

4. Significant burns (e.g. 20% of the body surface, or third-degree burns of 10% or more of the body surface).

5. Significant loss of vision.

6. Fatalities.

General Referrals

1. Claims meeting the eligibility criteria.

2. Employability assessments for the consideration of temporary partial disability benefits under section 192 of the *Act*.

3. Employability assessments for the consideration of permanent partial disability under section 196.

4. Consideration for continuity of income benefits.

5. Commutation investigations.

6. Reviews under section 203.

7. Evaluation of a permanently totally disabled worker's need or continued need for rehabilitation services, health care services, and personal supports in the three month period prior to the receipt of a retirement benefit.

8. Claims where recovery or re-employment is affected by:

   (a) psychological/social problems;
   (b) emotional problems;
   (c) financial stress;
   (d) substance abuse; and
   (e) vision/hearing problems.

Out of Province Referrals

Rehabilitation services requested of, or by, other Canadian Boards and Commissions are coordinated through reciprocal inter-jurisdictional agreement.

EFFECTIVE DATE:	September 1, 2015
AUTHORITY:	Section 155 of the *Act*.
CROSS REFERENCES:	Sections 156, 157, 162, 190, 192, 194, 195, 196, and 203 of the *Act;* and Item C5-33.10*, Wage-Loss Benefits For Temporary Total Disability*; Item C6-40.00, *Section 196 Permanent Partial Disability Benefits*; Item C6-45.00, *Lump Sums and Commutations*; Item C6-46.00, *Reconsideration of Prescribed Compensation Claims under Section 203*; Item C10-83.10, *Subsistence Allowances* (Section 6 Temporary Dependant Care During Period of Disability); Item C10-84.00, *Additional Benefits for Severely Disabled Workers* (Section 4.1 Personal Care Expenses or Allowances); Item C10-84.00, *Additional Benefits for Severely Disabled Workers* (Section 4.5 Independence and Home Maintenance Allowance); Item C11-86.00, *Vocational Rehabilitation – Eligibility Criteria*; Item C11-89.00, *Vocational Rehabilitation – Employability Assessments – Temporary Partial Disability and Permanent Partial Disability*; Item C18-116.30, *Retirement Benefits – Retirement Services and Personal Supports*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	January 1, 2021 – Housekeeping changes made to cross-references consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. September 1, 2015 – Policy revisions to remove referrals addressed elsewhere in policy. June 1, 2009 – Deleted references to Board officers. March 3, 2003 – Policy was amended to remove the reference to a review of then section 23(3) permanent partial disability award, consequential to the *Workers Compensation Amendment Act (No. 2), 2002*. November 1, 2002 – Clarification of guidelines for immediate and general vocational rehabilitation referrals. Replaced policy items, #86.10, #86.11, #86.12, #86.50, #86.60, and #86.80 of the *Rehabilitation Services & Claims Manual*, Volume II. Applied to decisions made on or after November 1, 2002 on claims adjudicated under the *Workers Compensation Act*, R.S.B.C. 1996, c. 492*,* as amended by the *Workers Compensation Amendment Act, 2002*.
APPLICATION:	Applies to all decisions made on or after September 1, 2015.

RE:	Vocational Rehabilitation − Process	ITEM:	C11-87.00

BACKGROUND

1. Explanatory Notes

This policy sets out the vocational rehabilitation process.

2. The Act

Section 155(1):

> To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

POLICY

The vocational rehabilitation process addresses the individual needs and circumstances of each worker.

Consultative Process

The Board functions as a catalyst, coordinator, initiator and expediter of all the disciplines involved in helping a worker to overcome the effects of a compensable injury/occupational disease. This demands a team approach, which involves the injured worker, the Board, medical practitioners, employers, union representatives, other agencies and members of the worker's family.

The rehabilitation process emphasizes ongoing consultation with the worker, the employer and, where applicable, the union, in order to maximize and maintain all opportunities for suitable re-employment.

The consultative process is guided by the Board in response to the worker's determination for vocational success.

While it is up to the Board to assess workers' needs and appropriate levels of rehabilitation assistance, it is ultimately the responsibility of workers to decide their own vocational future.

In order to carry out the disclosure of information necessary to administer this consultative process, a consent from the worker will normally be requested in advance.

Operational Process

The rehabilitation process involves five sequential phases of vocational exploration. The Board expedites this process in accordance with the vocational rehabilitation principles and goals.

PHASE I

Principle:

All efforts will be made to help the worker return to the same job with the same employer. Under the *Act*, some employers have a duty to maintain the employment of an injured worker, and to make any change to the work and/or the workplace that is necessary to accommodate a worker, to the point of undue hardship (see Item C5-35.20).

Rationale:

The worker returns to a known environment, maintains seniority and company benefits and, where applicable, remains in the same union. The employer benefits by virtue of retaining a trained and experienced employee.

Method:

Programs of physical conditioning, work assessment, refresher training or skill upgrading may be appropriate.

PHASE II

Principle:

Where the worker cannot return to the same job, the employer will be encouraged to accommodate job modification or alternate in-service placement. Under the *Act*, some employers have a duty to maintain the employment of an injured worker, and to make any change to the work and/or the workplace that is necessary to accommodate a worker, to the point of undue hardship (see Item C5-35.20).

Rationale:

As in Phase I, the worker and the employer mutually benefit from the continuation of the employment relationship.

Method:

Programs relevant to Phase I may be appropriate. In addition, work site/job modification and/or supplementary skill development involving training-on-the-job and/or formal training may be required.

PHASE III

Principle:

Where the employer is unable to accommodate the worker in any capacity, vocational exploration will progress to suitable occupational options in the same or in a related industrial sector, capitalizing on the worker's directly transferable skills.

Rationale:

The worker returns to a known or related industry**,** which best utilizes existing skills to optimize occupational potential. This may also allow the worker to retain union status where applicable.

Method:

The programs relevant to the preceding phases may be applicable. In addition, job search assistance may be indicated.

PHASE IV

Principle:

Where the worker is unable to return to alternate employment in the same or related industry, vocational exploration will progress to suitable occupational opportunities in all industries, recognizing the worker's inventory of transferable skills, aptitudes and interests.

Rationale:

The worker returns to suitable employment in a different industry, which best utilizes existing skills to optimize occupational potential.

Method:

All programs relevant to the preceding phases may apply.

PHASE V

Principle:

Where existing skills are insufficient to restore the worker to suitable employment, the development of new occupational skills will be considered.

Rationale:

The worker is equipped with new marketable skills with a view to optimizing occupational potential.

Method:

Training programs will be considered for the development of new occupational skills. Programs relevant to the preceding phases may apply to help the worker secure employment once trained.

EFFECTIVE DATE: January 1, 2024

AUTHORITY: Section 155 of the *Act*.

CROSS REFERENCES:
Item C5-35.10, *Duty to Cooperate*;
Item C5-35.20, *Duty to Maintain Employment*;
Item C11-85.00, *Vocational Rehabilitation − Principles and Goals*;
Item C11-88.00, *Vocational Rehabilitation − Nature and Extent of Programs and Services*;
Item C11-88.10, *Vocational Rehabilitation − Work Assessments*;
Item C11-88.20, *Vocational Rehabilitation − Work Site and Job Modification*;
Item C11-88.30, *Vocational Rehabilitation − Job Search Assistance*;
Item C11-88.40, *Vocational Rehabilitation − Training-on-the-Job*;
Item C11-88.50, *Vocational Rehabilitation − Formal Training*;
Item C11-88.60, *Vocational Rehabilitation − Business Start-ups*;
Item C11-88.70, *Vocational Rehabilitation − Legal Services*;
Item C11-88.80, *Vocational Rehabilitation − Preventative Rehabilitation*;
Item C11-88.90, *Vocational Rehabilitation − Relocation*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:
May 1, 2024 − Housekeeping change to update internal cross reference.
January 1, 2024 − Policy changes made consequential to implementing Division 3.1 of the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41).
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
June 1, 2009 – Deleted references to Board officers.
November 1, 2002 − Reformatted and revised policy to set out the vocational rehabilitation process and the five sequential phases of vocational exploration. Replaced policy items #87.10 and #87.20 of the *Rehabilitation Services & Claims Manual*, Volume II. Applies to decisions made on or after November 1, 2002 on claims adjudicated

under the *Workers Compensation Act*, R.S.B.C. 1996, c. 492 as amended by the *Workers Compensation Amendment Act, 2002*.

APPLICATION: Applies to all decisions made on or after January 1, 2024.

RE: Vocational Rehabilitation − Nature and Extent of Programs and Services **ITEM: C11-88.00**

BACKGROUND

1. Explanatory Notes

This policy sets out the nature and extent of vocational rehabilitation programs and services available for injured workers.

2. The Act

Section 155(1):

> To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

POLICY

PROGRAMS AND SERVICES

General

Programs and services in support of the vocational rehabilitation process may be implemented individually or in combination, as part of a rehabilitation plan.

Early Intervention

Vocational rehabilitation assistance should be provided as soon as a worker is medically able to participate in the worker's own vocational future.

Application of the Vocational Rehabilitation Process

The vocational rehabilitation process is generally applicable as follows:

Temporary total disability under section 191 of the *Act* – Phases I and II of the vocational rehabilitation process apply. Vocational rehabilitation services are limited to work assessments, work site/job modifications and to an advisory role regarding the worker's recovery and/or return to suitable work with pre-injury employer.

Temporary partial disability under section 192 of the *Act* – Phases I and II of the vocational rehabilitation process apply. Vocational rehabilitation services are limited to counselling, work assessments, graduated return to work ("GRTW"), placement assistance, mediation between worker and employer, and work site/job modifications.

Permanent partial disability under section 195 or 196 of the *Act* – Phases I through V of the vocational rehabilitation process apply. Vocational rehabilitation services may include counselling, work assessments (GRTW), placement assistance, mediation between worker and employer, work site/job modifications, job search, training-on-the-job, and formal training.

Permanent total disability under section 194 of the *Act* – Quality of life assistance may include vehicle modifications, home modifications, personal care allowances, independence and home maintenance allowances and temporary dependant care subsistence allowances.

Rehabilitation Plan

A rehabilitation plan is developed for each eligible worker. Ongoing medical opinion and a variety of Board and community resources assist the Board and the worker in developing the plan. The principles regarding medical opinion apply equally to the rehabilitation process.

The Board develops the plan in collaboration with the worker, the employer and appropriate health care providers. To demonstrate understanding of the plan, the plan should be signed by the worker, the Board and where appropriate, the employer.

The written rehabilitation plan:

- Defines the overall vocational goal. The plan is considered appropriate if the worker has a reasonable probability of successfully achieving the vocational goal.

- Outlines the supporting rationale, which makes the vocational goal attainable. The plan will clearly document how the worker's vocational profile matches the targeted suitable occupation. A description of the worker's vocational profile will include objective functional capacity, education, existing transitional skills or projected skills, aptitudes, training, interests and personal and occupationally significant characteristics.

- Describes a suitable occupation in which the worker can competitively pursue employment upon achievement of the vocational goal. This will be based on recognized methods of occupational classification. Where applicable, the description will include community-specific features of the occupation as determined through job analysis.

- Details the specific programs and services for the vocational goal to be attained and outlines the obligations of the participants.

- Details the methods, techniques and supports, which will be utilized to assist the worker in attaining the vocational goal. The sponsorship opportunities of other agencies are considered in providing integrated service delivery. Their availability does not limit the Board's provision of additional services in accordance with its policies.

- Outlines the wage-loss equivalency benefits and/or other allowances (such as transportation and subsistence allowances) which will accompany the plan.

- Indicates the timeframes associated with the overall plan and its component steps.

A worker is entitled to one rehabilitation plan. The Board will monitor the plan to determine if the plan is progressing as anticipated. A plan may be modified or a new plan substituted where:

- The worker's compensable condition deteriorates or improves, making the initial plan inappropriate in relation to the goal; and/or

- There are significant developments in the vocational rehabilitation process, impacting the expected outcome of the plan.

Approval by the Director of Vocational Rehabilitation Services is required in order to proceed with the development of a new plan.

All involved parties will acknowledge the modified or new plan. The requirements for developing the initial plan apply to the modified or new plan.

Financial Implications/Cost Effectiveness

Each plan must set out the financial implications of implementing the plan and/or its cost effectiveness. The analysis may include such things as a comparison of the estimated cost of the necessary vocational services, the remaining compensation benefits that the worker is entitled to, the estimated cost of alternative rehabilitation plans, and the estimated benefit costs if no return to work services are provided. The analysis must also set out when it is expected that specific costs will be experienced.

Discontinuation of Vocational Rehabilitation Services

Vocational rehabilitation services may be discontinued where:

- the worker refuses available employment that is considered suitable;
- the worker fails to cooperate with the vocational rehabilitation process;
- the worker has, for personal reasons, withdrawn from the labour force;
- non-compensable medical, psycho-social or financial problems alone preclude active participation in the rehabilitation process;
- the worker retires or is deemed to have retired; or
- the plan is completed and it is neither necessary nor cost effective to provide further vocational rehabilitation assistance.

Wage-Loss Equivalency and Other Benefits

Wage-loss equivalency benefits provided by the Board are payable only when wage-loss benefits have concluded and follow the same rules with regard to the deduction of permanent disability benefits. These benefits may be provided while workers are either awaiting or undertaking specific vocational programs.

Transportation allowances and subsistence allowances may also be considered in support of vocational programs.

The sponsorship opportunities of other agencies are considered in providing integrated service delivery, but their availability does not diminish the Board's primary service and funding responsibilities.

EFFECTIVE DATE: January 1, 2024
AUTHORITY: Section 155 of the *Act*.
CROSS REFERENCES: Sections 154.2, 154.3 190, 191, 192, 194, 195, and 196 of the *Act;*
Item C5-35.10, *Duty to Cooperate*;
Item C5-35.20, *Duty to Maintain Employment*;
Chapter 9, *Average Earnings*;
Item C9-69.00, *Maximum Amount of Average Earnings*;
Item C9-70.00, *Average Earnings on Reopened Claims*;
Item C10-83.00, *Transportation*;
Item C10-83.10, *Subsistence Allowances*;
Item C10-84.00, *Additional Benefits for Severely Disabled Workers*;

Item C11-85.00, *Vocational Rehabilitation – Principles and Goals*;
Item C11-87.00, *Vocational Rehabilitation – Process*;
Item C12-97.30, *Medical Evidence*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:

January 1, 2024 − Policy changes made consequential to implementing Division 3.1 of the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41).
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
February 1, 2020 − Policy amended to add heading related to wage-loss equivalency and other benefits and to remove language that developments in VR process allowing a VR plan to be changed be 'unanticipated'.
September 1, 2015 − Policy revised to remove Vice President approval, and direct that the Director of VR Services is only required to approve the development of a new VR plan. Amendments also ensure workers who receive permanent partial disability compensation under sections 195 and 196 of the *Act* are treated consistently, and the elements that must be included in the financial analysis of a VR plan are revised.
June 1, 2009 – Deleted references to Board officer, Vocational Rehabilitation Services and Compensation and Rehabilitation Services.
November 1, 2002 – Reformatted and revised policy to set out the nature and extent of programs and services generally applicable in relation to the entitlement provisions of the *Act*. Amendments also included the criteria for modifying or creating a new plan and guidance on when vocational rehabilitation services may be discontinued. Replaced policy items #87.00 and #88.00 of the *Rehabilitation Services & Claims Manual*, Volume II and applies to decisions made on or after November 1, 2002 on claims adjudicated under the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as amended by the *Workers Compensation Amendment Act, 2002*.

APPLICATION:

Applies to all decisions made on or after January 1, 2024.

RE:	Vocational Rehabilitation − Work Assessments	ITEM:	C11-88.10

BACKGROUND

1. Explanatory Notes

This policy describes work assessment programs.

2. The Act

Section 155(1):

> To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

POLICY

Work Assessments

A work assessment program is a method of determining or enhancing a worker's employment capabilities and potential in an actual work environment with an employer, or in a simulated setting using functional evaluation methodology.

Guidelines

Subject to policy in Item C11-88.00, the following guidelines on work assessments apply.

1. When a work assessment with an employer takes place prior to full medical recovery and is intended primarily as a therapeutic measure to assist increasing levels of work activity, the program is normally referred to as a "Graduated Return to Work". This program is commonly a first step in a worker's successful reinstatement with the pre-injury employer.

2. Work assessments also allow employers and workers to assess the viability of employment in a particular job and are frequently used together with training-on-the-job programs.

Expenditures

1. The Board provides financial assistance to workers who are participating in work assessment programs, either through a continuation of wage-loss benefits under section 191 or 192 of the *Act*, or payment of rehabilitation allowances under section 155 when wage-loss benefits are no longer payable.

2. Costs arising from injuries or aggravations that occur during the course of Board-sponsored work assessments with an employer are not charged to the participating employer.

EFFECTIVE DATE:	November 1, 2002
AUTHORITY:	Sections 155, 190, 191, and 192 of the *Act*.
CROSS REFERENCES:	Item C11-87.00, *Vocational Rehabilitation − Process*; Item C11-88.00, *Vocational Rehabilitation − Nature and Extent of Programs and Services*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. November 1, 2002 − Replaced policy items #88.10 - #88.12 of the *Rehabilitation Services & Claims Manual*, Volume II.
APPLICATION:	To decisions made on or after November 1, 2002 on claims adjudicated under the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, or the *Act*.

RE:	Vocational Rehabilitation − Work Site and Job Modification	ITEM:	C11-88.20

BACKGROUND

1. Explanatory Notes

This policy describes work site and job modification.

Under section 154.3, some employers must make any change to the work and/or the workplace that is necessary to accommodate a worker, short of undue hardship.

In addition to the obligations imposed by section 154.3, all employers have an obligation to comply with human rights legislation to accommodate workers with disabilities. This obligation is set out in British Columbia's *Human Rights Code*, and for federally regulated employers, the *Canadian Human Rights Act*.

2. The Act

Section 154.3, in part:

> (1) Except as provided in subsection (2), this section applies in relation to an employer and a worker of the employer if the worker has been employed by the employer, on a full- or part-time basis, for a continuous period of at least 12 months before the date the worker was injured.
>
> (2) This section does not apply in relation to the following:
>
> (a) a person who is a worker only because the person is deemed under the Act to be a worker;
>
> (b) an employer who regularly employs fewer than 20 workers;
>
> (c) a class of employers or workers or an industry or class of industries prescribed by the Lieutenant Governor in Council.
>
> …
>
> (5) An employer must, to the point of undue hardship, make any change to the work or the workplace that is necessary to accommodate a worker.

Section 155(1):

> To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

POLICY

Work Site and Job Modification

All employers are encouraged to accommodate an injured worker, which includes making any change to the work and/or the workplace that is necessary. The Board may provide assistance to alter work sites or modify jobs to facilitate re-employment.

Some employers have an obligation under section 154.3 to change the work and/or the workplace to the point of undue hardship (see policy in Item C5-35.20). In these cases, if the change would result in undue hardship for the employer, the Board may consider assisting the employer with altering the work site or modifying the job.

Guidelines

Subject to policy in Item C11-88.00, the following guidelines on work site and job modification apply.

1. Assistance of this nature may occur where it is advantageous in returning workers to employment.

2. Modifications are considered and undertaken in consultation with workers, employers, unions and treating professionals.

Expenditures

1. The Board may provide financial assistance for the modification of jobs and work sites, including expenditures for special equipment and/or tools, if appropriate and necessary in facilitating the worker's return to employment.

2. In some instances, it may be appropriate to share the costs of these expenditures with employers.

EFFECTIVE DATE:	January 1, 2024
AUTHORITY:	Section 155 of the *Act*.
CROSS REFERENCES:	Item C5-35.20, *Duty to Maintain Employment*; Item C11-87.00, *Vocational Rehabilitation − Process*; Item C11-88.00, *Vocational Rehabilitation − Nature and Extent of Programs and Services*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	May 1, 2024 – Housekeeping change to update internal cross reference. January 1, 2024 – Policy changes made consequential to implementing Division 3.1 of the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41). April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. November 1, 2002 − Replaced policy items #88.20, #88.21, and #88.22 of the *Rehabilitation Services & Claims Manual*, Volume II.
APPLICATION:	Applies to all decisions made on or after January 1, 2024.

RE: Vocational Rehabilitation – Job Search Assistance **ITEM: C11-88.30**

BACKGROUND

1. Explanatory Notes

This policy describes the Board's job search assistance program.

2. The Act

Section 155(1):

> To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

POLICY

Job Search Assistance

Job search assistance may be provided to workers who require help in securing appropriate employment.

Guidelines

Subject to policy in Item C11-88.00, the following guidelines on job search assistance apply.

1. Job search assistance would normally be introduced to help equip workers with the knowledge and skills to conduct a successful search for employment. Assistance may include:

   (a) vocational assessment and goal-setting through individual and/or group counselling;

   (b) referral to internal and external employment resources;

   (c) marketing to prospective employers;

   (d) financial assistance.

2. Eligibility for job search assistance and its continuance is conditional upon the active cooperation of the worker with the Board. Workers may be required to provide proof that they are earnestly seeking employment, or awaiting a definite job opportunity.

3. Job search assistance may be provided for up to 12 cumulative weeks.

   The Board may approve extensions up to 26 weeks based on the following criteria:

   - Labour market data supports a greater average number of weeks of job search for the worker's home geographic area and/or the worker's occupation;
   - The severity of the injury and resulting disability are such that 12 weeks to locate suitable employment will be inadequate; or
   - The worker has actively participated in job search and there is objective evidence that a period greater than 12 weeks is required to locate suitable employment that will allow the worker to return to an occupational category comparable in terms of earning capacity to the pre-injury occupation.

   Extensions beyond 26 weeks must be approved by the Director of Vocational Rehabilitation Services.

Expenditures

The Board may provide financial assistance in the form of a job search allowance. This is a discretionary vocational rehabilitation benefit which applies if the worker is actively seeking or returning to appropriate employment, attending a designated job search program, or awaiting a confirmed job opportunity. The amount of the allowance will not exceed wage-loss equivalency.

EFFECTIVE DATE:	September 1, 2015
AUTHORITY:	Section 155 of the *Act*.
CROSS REFERENCES:	Item C11-87.00, *Vocational Rehabilitation – Process*; Item C11-88.00, *Vocational Rehabilitation – Nature and Extent of Programs and Services*; Item C11-88.90, *Vocational Rehabilitation – Relocation*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:

April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
September 1, 2015 – Revised policy provides that job search assistance may be provided for up to 26 weeks. Extensions beyond 26 weeks must be approved by the Director of VR Services.
June 1, 2009 – Deleted references to Board officer and Compensation and Rehabilitation Services.
November 1, 2002 – Reformatted and revised policy to set out that job search assistance may be provided for up to 12 weeks. Extensions beyond 12 weeks must be approved by the VP of Compensation and Rehabilitation Services or the Director of VR Services. Criteria were also provided for granting extensions. Replaced policy items #88.30 - #88.32 of the *Rehabilitation Services & Claims Manual*, Volume II. Applied to decisions made on or after November 1, 2002 on claims adjudicated under the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as amended by the *Workers Compensation Amendment Act, 2002*.

APPLICATION:

This Item applies to all decisions made on or after September 1, 2015.

RE:	Vocational Rehabilitation − Training-on-the-Job	ITEM:	C11-88.40

BACKGROUND

1. Explanatory Notes

This policy describes the Board's training-on-the-job program.

2. The Act

Section 155(1):

> To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

POLICY

Training-on-the-Job

Training-on-the-job is a shared-cost program which is undertaken at an employer's work site to provide the worker with specific skills leading directly to employment.

Guidelines

Subject to the policy in Item C11-88.00, the following guidelines apply for training-on-the-job programs.

1. Training-on-the-job assistance may be provided to enhance or develop new occupational skills.

2. While the worker is undertaking a training-on-the-job program, absences are usually treated according to the training employer's policy on absenteeism. That is, if the employer deducts the worker's pay for an absence, so will the Board. If the employer pays for the absence, the Board will pay as well.

3. Training-on-the-job assistance may be provided for up to 26 weeks.

The Board may approve training-on-the-job assistance of more than 26 weeks based on the following criteria:

- A program greater than 26 weeks will maximize long-term earning capacity up to the pre-injury wage rate;
- A program greater than 26 weeks will result in permanent long-term employment;
- A program greater than 26 weeks is necessary to develop/demonstrate the required occupational skill levels; or
- A program greater than 26 weeks is required for ticketing and/or certification in the identified occupation.

The timeframe for training-on-the-job will be part of the rehabilitation plan. Extensions beyond 26 weeks must be approved by the Director of Vocational Rehabilitation Services.

Expenditures

1. Financial assistance for a training-on-the-job program will normally be provided on a shared-cost basis with the training employer. The Board's contribution will usually decrease, on a sliding scale, as the program proceeds and the worker's productivity increases. The portion of the worker's wages paid by the Board will normally not exceed the worker's wage-loss rate.

   Training-on-the-job allowances will be calculated in a manner similar to the calculation of wage-loss benefits. In general the sum of the wages from the training employer and the gross payments from the Board to the worker will be equal to the worker's pre-injury wage rate. Where the worker's pre-injury wage rate exceeds the maximum wage rate as set under section 209 of the *Act*, the Board's contribution will be calculated by substituting the maximum wage rate for the pre-injury wage rate. In that case the sum of the wages from the training employer and the gross payments from the Board to the worker will be equal to the maximum wage rate.

2. Expenditures under this program will usually be paid directly to the employer, so that the worker will be covered by Employment Insurance, Canada Pension Plan and any other company benefits.

3. Permanent disability benefits are not deducted from training allowances for training-on-the-job programs when paying the employer.

4. Nothing in this Item should be interpreted to prohibit the Board from negotiating a wage with the training employer that exceeds either the maximum wage rate or the worker's pre-injury wage. The Board will seek to maximize the wages paid to the worker by the training employer while recognizing that it is necessary and desirable to provide some incentive to employers to choose injured workers for training-on-the-job positions.

Injury in the Course of Training-on-the-Job

The Board considers it essential to encourage employers to provide training and employment opportunities for injured workers. One way of doing this is to exclude from the employer's experience rating, the costs of certain employment injuries and aggravations occurring in the course of a training-on-the-job program.

There are two different training-on-the-job situations to be considered:

1. The employer is not paying the worker; the Board is paying full benefits.

   All costs resulting from the aggravation of the injury are excluded from experience rating, whatever the nature of the injury.

2. The employer is paying a partial wage to the worker who is also receiving payments from the Board; or the Board is reimbursing the employer part of the worker's salary.

   If there is an aggravation of the old injury, or the old injury contributes significantly to the occurrence of the new injury, all the resulting costs are excluded from experience rating, whatever the nature of the injury.

   If the old injury made no significant contribution to the new injury, the Board will exclude from experience rating a proportion of the costs of the new claim equal to the percentage of the worker's wages being paid or reimbursed by the Board.

The above policy applies whether the employer at the time is a new employer or the worker's original employer.

In addition to relief for the individual employer for experience rating, the employer's sector or rate group may be eligible for relief under section 240(1)(d).

EFFECTIVE DATE: January 1, 2021
AUTHORITY: Section 155 of the *Act*.
CROSS REFERENCES: Item C11-87.00, *Vocational Rehabilitation – Process*;

Item C11-88.00, *Vocational Rehabilitation – Nature and Extent of Programs and Services*;
Item C11-88.50, *Vocational Rehabilitation – Formal Training*;
Item C17-114.00, *Experience Rating Cost Exclusions;*
Item C17-114.40, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:

January 1, 2021 – Policy changes made consequential to implementing the permanent partial disability benefits provisions of the *Workers Compensation Amendment Act, 2020* (Bill 23).
October 21, 2020 – Amended to reflect amendment to maximum wage rate provisions in the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
September 1, 2015 – Revised policy removes requirement for the timeframe for training-on-the-job to be determined before a VR plan is implemented.
June 1, 2009 – Deleted reference to Compensation and Rehabilitation Services.
November 1, 2002 – Reformatted and revised policy provides that training-on-the-job assistance may be provided for up to 26 weeks. Extensions beyond 26 weeks must be approved by the VP of Compensation and Rehabilitation Services or the Director of VR Services. Criteria are also provided for granting extensions. Replaced Items #88.40 - #88.43 of the *Rehabilitation Services & Claims Manual*, Volume II. Applied to decisions made on or after November 1, 2002 on claims adjudicated under the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as amended by the *Workers Compensation Amendment Act, 2002*.

APPLICATION:

Applies to all decisions, including appellate decisions, made on or after January 1, 2021.

RE:	Vocational Rehabilitation − Formal Training	ITEM:	C11-88.50

BACKGROUND

1. Explanatory Notes

This policy sets out the Board's formal training program.

2. The Act

Section 155(1):

> To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

POLICY

Formal Training

Subject to the policy in Item C11-88.00, the following guidelines apply to formal training.

Formal training refers to a range of courses or programs which:

1. add to, or upgrade a worker's existing skills or qualifications;
2. provide new occupational skills.

These may include full-time or part-time trades, technical or academic programs offered through recognized training or educational institutions. These programs are of short duration of less than 26 weeks and should be identified as having an immediate positive impact on the worker's employability. Programs of more than 26 weeks duration must be approved by a Vice-President or the Director of Vocational Rehabilitation Services.

The following criteria apply in considering whether a program of more than 26 weeks is approved:

- A program greater than 26 weeks is required to assist a worker in mitigating a worker's loss of earnings;

- A program of less than 26 weeks is not adequate to provide new occupational skills; or

- The rehabilitation plan that is developed identifies and provides supporting documentation for a lengthier formal training program based on the worker's objective functional capacity, existing transitional skills, aptitudes, education and training or labour market demands.

Levels of Support

Where a worker, who has sustained a compensable injury or occupational disease, wishes to undertake a formal training program and seeks assistance from the Board, the proposed program must be classified in one of the following three categories:

1. Training Related Directly to the Disability

   The Board should provide the cost of any formal training program considered reasonably necessary to overcome the effects of any residual disability. This can also apply to preventative rehabilitation.

   (a) The primary guideline is that the Board should, where practical, support a program sufficient to restore the worker to an occupational category comparable in terms of earning capacity to the pre-injury occupation.

   (b) A secondary guideline is that the gravity of the residual disability is a relevant factor. The Board should go to greater lengths in cases where the residual disability is serious than in cases where it is minor.

   Where a worker is eligible for a formal training program under this heading, the support provided under section 155 of the *Act* should be sufficient to enable the worker to complete the program. Workers should not be expected to use their own resources or to commute their permanent disability benefits for this purpose.

2. Training Related Partly to the Disability

   Workers may sometimes want to blend their rehabilitation into a general advancement of their education, or pursue a vocational ambition that exceeds what would otherwise be provided under section 155 of the *Act*.

   For example, a worker is injured in a heavy manual occupation and is unable to return to heavy manual work. In discussion with the Board, it appears that there is a 26-week program that would provide occupational skills for a position with earning capacity and prospects at least as good

as the pre-injury occupation; but rather than pursue this option the worker prefers a more extensive one-year program.

The Board should not deny the rehabilitation assistance that would have been provided if the worker had chosen the 26-week training program, but neither should it generally finance an educational advancement that goes beyond what is reasonably necessary as rehabilitation for the injury.

In cases of this kind, the Board will estimate the total expenditure that would have been incurred under section 155 of the *Act* if the worker had taken a program considered reasonably necessary to overcome the effects of the compensable injury. The worker will then be offered that amount as a contribution to the cost of the preferred vocational plan.

If the injury is very severe, the Board might treat the case under Category 1 and support the whole program. Rehabilitation is not limited to restoring earning capacity and, in cases of catastrophic or very serious injury, the Board should do all that is reasonably possible and appropriate to facilitate the functional restoration and development of the worker. In these cases, a formal training program may be wholly supported by the Board notwithstanding:

(a) that it goes beyond what is necessary to restore the pre-injury earning capacity of the worker, or

(b) that it may not improve earning capacity at all.

3. Training Unrelated to the Disability

Sometimes, recovery from an injury coincides with a desire for a change of occupation, or for some formal training program that the worker might well have undertaken regardless of the injury. The jurisdiction of the Board under section 155 of the *Act* is to provide assistance reasonably necessary as rehabilitation for a compensable injury. Thus, it is not a function of the Board to finance training that is part of an ordinary career pattern or that is desired by the worker for reasons unrelated to the injury.

Such training would, therefore, not be supported under section 155. If the worker wished to meet the cost of the program by a commutation of permanent disability benefits, that is something the Board might consider.

Guidelines

1. Formal training programs are normally undertaken for the purpose of improving a worker's long-term employment and earnings potential.

2. Before deciding on a formal training program, it is important that the worker's desires, abilities, aptitudes, interests and educational readiness are assessed in order to ensure a probability of success. The program must also be compatible with the worker's physical capabilities and any ongoing medical treatment.

3. Decision-making regarding the type and appropriateness of formal training programs is a collaborative process which takes into consideration the desire and intent of the worker and all relevant assessment and labour market information. The Board determines the feasibility of the program(s) under consideration and decides whether to recommend sponsorship.

4. Ongoing support and sponsorship of formal training programs are contingent upon the worker's active cooperation and participation in the process. If the worker does not meet the attendance and progress requirements of the program, financial sponsorship may be suspended or withdrawn. Discussion with the worker will determine whether further or alternate assistance is appropriate.

Expenditures

When it is decided to support a formal training program related directly to the disability, the assistance provided under section 155 of the *Act* will normally include:

1. Training allowances at wage-loss equivalency, when the worker is enrolled in a full-time program.

2. Tuition fees and any necessary books, materials or equipment.

3. Travel and subsistence where appropriate.

When it is decided to support a formal training program related partly to the disability, the Board will estimate the total expenditure that would otherwise have been incurred under section 155 of the *Act*. The worker will then be offered that amount as a contribution to the cost of the preferred program. This contribution will normally be paid by installment and will be subject to the cost of living adjustments provided in section 334 of the *Act*.

Injury in the Course of Training

A worker undergoing a course of rehabilitation training sponsored by the Board does so in the circumstances described below:

1. The trainee may be attending a school of training specifically operated as such and for which course of training the Board pays a fee to the school,

while at the same time paying the trainee the allowance prescribed by Board regulations.

2. A trainee may, by arrangement, be receiving training in an industrial or business establishment, receiving no remuneration from the employer in the establishment, but only receiving the allowance prescribed by Board regulations. At the same time, the Board may be paying something by way of a training fee to the employer in the establishment.

In the above circumstances, the Board takes the position that the trainee is not a "worker" employed by the participating employer in the course of rehabilitation training. Should the trainee receive further injury in the course of training, the Board regards such further injury as a continuation of the original disability. The two main objectives are:

1. that the injured trainee shall receive compensation under the *Act*, and

2. that an employer who cooperates and assists the Board in rehabilitating an injured worker shall not be penalized for so doing.

In the case of an aggravation or new injury to a trainee, the Board will normally exclude the costs from the employer's experience rating. In addition, the employer's sector or rate group may be eligible for relief under section 240(1)(d).

The above policy applies whether the employer at the time is a new employer or the worker's original employer.

Joint Sponsorship

Where a worker is undertaking a training program sponsored by another agency, and:

1. the circumstances are such that a similar program would have been supported by the Board, and

2. the level of support provided by the other agency is less than would have been provided by the Board,

the Board will provide support to the extent of the difference.

EFFECTIVE DATE:	January 1, 2021
AUTHORITY:	Section 155 of the *Act*.
CROSS REFERENCES:	Item C3-20.00, *Employer-Provided Facilities*; Item C3-22.00, *Compensable Consequences*; Item C6-45.00, *Lump Sums and Commutations*;

Item C10-83.00, *Transportation*;
Item C10-83.10, *Subsistence Allowances*;
Item C11-87.00, *Vocational Rehabilitation – Process*;
Item C11-88.00, *Vocational Rehabilitation – Nature and Extent of Programs and Services*;
Item C11-88.80, *Vocational Rehabilitation – Preventative Rehabilitation*;
Item C17-114.00, *Experience Rating Cost Exclusions;*
Item C17-114.40, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*, of the *Rehabilitation Services & Claims Manual,* Volume II.

HISTORY:

November 24, 2022 – Housekeeping changes consequential to implementing the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41).
January 1, 2021 – Policy changes made consequential to implementing the permanent partial disability benefits provisions of the *Workers Compensation Amendment Act, 2020* (Bill 23).
October 21, 2020 – Housekeeping amendments to ensure consistent terminology.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
September 1, 2015 – Revised policy for housekeeping changes.
June 1, 2009 – Deleted reference to Compensation and Rehabilitation Services and Board officer.
November 1, 2002 – Reformatted and revised policy to set out that formal training programs may be provided for up to 26 weeks. Programs of more than 26 weeks must be approved by the VP of Compensation and Rehabilitation Services or the Director of VR Services. Criteria are also provided for considering whether a program of more than 26 weeks is approved. Replaced policy items #88.50 - #88.55 of the *Rehabilitation Services & Claims Manual,* Volume II. Applied to decisions made on or after November 1, 2002 on claims adjudicated under the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as amended by the *Workers Compensation Amendment Act, 2002*.

APPLICATION:

Applies to all decisions, including appellate decisions, made on or after January 1, 2021.

RE: Vocational Rehabilitation − Business Start-ups **ITEM: C11-88.60**

BACKGROUND

1. Explanatory Notes

This policy sets out the Board's business start-up program.

2. The Act

Section 155(1):

> To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

POLICY

Business Start-ups

The Board may contribute to the cost of starting or enhancing a viable business for a worker in lieu of other rehabilitation measures.

Business start-ups will only be approved in limited situations where the Board is satisfied that the worker has demonstrated previous business experience and presents a viable business plan. In each case where a business start-up is contemplated as a vocational rehabilitation measure, the Board will obtain, with the worker's written consent, an appraisal of the viability of the proposed business from the Business Development Bank of Canada or some similar organization before a final decision is made. Before consideration can be given to a business-start-up plan, the Director, Vocational Rehabilitation Services must approve a business feasibility study. The Director, Vocational Rehabilitation Services, must also approve all business start-ups.

The amount of financial assistance will normally not exceed the amount that would have been paid if the worker had undertaken a vocational rehabilitation program considered reasonable and necessary to overcome the effects of the compensable injury.

When considering vocational rehabilitation expenditures for business start-ups, the basic guidelines for starting a business apply.

EFFECTIVE DATE:	November 1, 2002
AUTHORITY:	Section 155 of the *Act*.
CROSS REFERENCES:	Item C6-45.00, *Lump Sums and Commutations*; Item C11-88.00, *Vocational Rehabilitation − Nature and Extent of Programs and Services*, of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	January 1, 2021 – Housekeeping change made to cross-reference consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. Replaced policy item #88.60 of the *Rehabilitation Services & Claims Manual,* Volume II.
APPLICATION:	To decisions made on or after November 1, 2002 on claims adjudicated under the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, or the *Act*.

RE:	Vocational Rehabilitation − Legal Services	ITEM:	C11-88.70

BACKGROUND

1. Explanatory Notes

This policy sets out the legal assistance that may be provided in relation to vocational rehabilitation services.

2. The Act

Section 155(1):

> To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

POLICY

Legal Services

While legal assistance is not normally required as a rehabilitation measure, the provision of legal assistance might be considered, where appropriate, as part of the worker's rehabilitation offered under section 155 of the *Act*, either at the request of the worker or at the initiative of the Board.

Legal advice is not provided in respect of any matter that the Board is or may be adjudicating.

The following examples illustrate some of the circumstances in which legal assistance by the Board may be considered.

1. Indebtedness or Insolvency

   Where claims are being made against a worker which are an impediment to recovery from an occupational injury or disease, the provision of legal advice by the Board might be considered as part of the worker's rehabilitation.

2. Matrimonial Problems

Cases sometimes arise in which the threat of wage garnishment for the enforcement of a maintenance order is a cause of anxiety, or in other respects an impediment to a return to work. Legal assistance by the Board in these circumstances is a possibility that might be considered.

3. Conveyancing

A worker who owns a home may be required by the nature of the injury to move (e.g. paraplegia). In such a case, conveyancing services might be considered as part of the rehabilitation assistance and this may be done within the Legal Services Division of the Board or in the form of paying the fees and disbursements for a lawyer in private practice.

4. Workers' Estates

Where workers sustain serious injuries that render them unable to administer their own affairs, their family may need legal advice and assistance to make alternative arrangements.

5. Advice to a Surviving Spouse

The Board cannot provide any legal assistance that may be required in relation to the administration of an estate of a deceased worker. Nor can the Board provide legal assistance in relation to any other problems resulting directly from a death; but if any legal problems should arise in relation to the employment of dependants, legal advice in respect of such problems might be considered as one aspect of counselling.

6. Other Situations

The examples set out in this Item are mentioned only by way of illustration. They are not an exhaustive list of the circumstances in which legal assistance might be provided.

EFFECTIVE DATE: June 1, 2009
AUTHORITY: Section 155 of the *Act*.
CROSS REFERENCES:
HISTORY: April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
June 1, 2009 – Deleted reference to officer.

November 1, 2002 − Reformatted and revised policy to set out the legal assistance that may be provided in relation to vocational rehabilitation. Replaced policy item #88.70 of the *Rehabilitation Services & Claims Manual,* Volume II. Applied to decisions made on or after November 1, 2002 on claims adjudicated under the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as amended by the *Workers Compensation Amendment Act, 2002*.

APPLICATION: Applies on or after June 1, 2009.

RE:	Vocational Rehabilitation – Preventative Rehabilitation	ITEM:	C11-88.80

BACKGROUND

1. Explanatory Notes

This policy sets out preventative rehabilitation assistance that may be provided to workers.

2. The Act

Section 155(1):

> To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

POLICY

Preventative Rehabilitation

Preventative rehabilitation is intended to provide assistance to workers who can return to their previous jobs, but have been medically deemed to be at undue risk of:

1. permanent disability due to vulnerability, or
2. increased permanent disability.

Cases involving occupational disease or prior claims for the same injury (mainly joints and backs) are the primary focus of preventative rehabilitation.

Once eligibility for preventative assistance has been established, the rehabilitation process applies.

EFFECTIVE DATE: November 1, 2002
AUTHORITY: Section 155 of the *Act*.

CROSS REFERENCES:	Item C11-87.00, *Vocational Rehabilitation − Process*, of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	October 21, 2020 – Housekeeping amendments to ensure consistent terminology. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. Replaced policy item #86.30 of the *Rehabilitation Services & Claims Manual,* Volume II.
APPLICATION:	To decisions made on or after November 1, 2002 on claims adjudicated under the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, or the *Act*.

RE:	Vocational Rehabilitation − Relocation	ITEM:	C11-88.90

BACKGROUND

1. Explanatory Notes

This policy sets out the Board's guidelines on relocation.

2. The Act

Section 155(1):

> To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

Section 192(1), in part:

> … if a temporary partial disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the difference between
>
> (a) the worker's average net earnings before the injury, and
>
> (b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:
>
> (i) the average net earnings that the worker is earning after the injury;
>
> (ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury.

Section 196:

(1) This section applies in relation to a permanent partial disability if an amount required under section 195 is less than an amount required under this section.

(2) *Repealed*.

(3) The Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the difference between

(a) the average net earnings of the worker before the injury, and

(b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:

(i) the average net earnings that the worker is earning after the injury;

(ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury.

POLICY

Relocation is considered to be a reasonable option for a worker after all other return-to-work options have been considered. Where no suitable occupations that will maximize the worker's post-injury earning capacity are available within a reasonable commuting distance of the worker's home community, the Board may recommend that the worker relocate to an area where there are greater prospects for employment opportunities in a suitable occupation.

An offer by the Board to relocate a worker will be made on the basis of the worker's individual circumstances. The primary factor to be considered is mitigation of the worker's long-term loss of earning capacity. A determination must be made that employment opportunities, on relocation, would substantially reduce the worker's post-injury loss of earnings.

Other factors that may be considered in determining whether it would be reasonable for a worker to relocate include age, family situation and/or connection to the community. The connection to the community must be significant and refer to the worker's obligations and responsibilities to the community separate from the worker's family situation. The evidence must support a finding that these other factors, either alone or in combination, would make it unreasonable for the Board to consider relocation. The

primary factor will be the deciding factor unless the other factors considered either separately or in combination clearly outweigh the mitigation of the worker's loss of earning capacity.

The Board will pay reasonable expenses of relocation. Expenses paid by any other agency, may be deducted from the amount to be paid by the Board.

If the Board determines that relocation is reasonable and relocation expenses have been offered, the worker's benefits may be calculated as if the worker relocated.

EFFECTIVE DATE:	February 1, 2020
AUTHORITY:	Sections 155, 192 and 196 of the *Act*.
CROSS REFERENCES:	Item C5-33.20, *Wage-Loss Benefits For Temporary Partial Disability*; Item C6-40.00, *Section 196 Permanent Partial Disability Benefits*; Item C11-89.00, *Vocational Rehabilitation − Employability Assessments − Temporary Partial Disability and Permanent Partial Disability*, of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	January 1, 2021 – Housekeeping changes made to the *Act* portion of the Background section to reflect amendments to the *Act* by the *Workers Compensation Amendment Act*, *2020* (Bill 23). April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Policy amended to provide guidance on the legal issues of standard of proof and evidence. Replaced, in part, policy item #40.12.
APPLICATION:	Applies to all decisions made on or after February 1, 2020.

RE:	Vocational Rehabilitation − Employability Assessments − Temporary Partial Disability and Permanent Partial Disability	ITEM:	C11-89.00

BACKGROUND

1. Explanatory Notes

This policy sets out the employability assessment process for temporary partial disability and permanent partial disability.

2. The Act

Section 155(1):

> To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

Section 192(1), in part:

> … if a temporary partial disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the difference between
>
> (a) the worker's average net earnings before the injury, and
>
> (b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:
>
> (i) the average net earnings that the worker is earning after the injury;
>
> (ii) the average net *earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury*. (emphasis added)

Section 196:

(1) This section applies in relation to a permanent partial disability if an amount required under section 195 is less than an amount required under this section.

(2) *Repealed*.

(3) The Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the difference between

(a) the average net earnings of the worker before the injury, and

(b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:

(i) the average net earnings that the worker is earning after the injury;

(ii) the average net *earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury.* (emphasis added)

POLICY

Employability Assessments

Sections 192 and 196 of the *Act* direct the Board to estimate what a worker is capable of earning in a suitable occupation. This may require an employability assessment.

One of the functions of Vocational Rehabilitation Services is to assist in the assessment of employability for temporary partial disability and permanent partial disability under sections 192 and 196 of the *Act*.

Temporary Partial Disability

Where a worker is medically judged to be only partially disabled and the condition remains temporary, any further wage-loss benefits may be processed under section 192 of the *Act*. In most cases, the employability assessment under section 192 is conducted without a referral to Vocational Rehabilitation Services. The goal is to identify suitable occupations, along with estimated earnings, that maximize the worker's short-term earning capacity up to the pre-injury wage rate. In most cases, the focus of the assessment is a return to work with the pre-injury employer.

In cases where the worker is not able to return to work in some capacity, a referral to Vocational Rehabilitation Services may be required. In these situations, a more comprehensive employability assessment may need to be completed where a suitable return to work cannot be arranged. For example, if there is no attachment to the pre-injury employer, suitable and available occupations in the labour market will be considered.

Vocational Rehabilitation Services provides the documented objective evidence of what the worker is earning or is capable of earning, not the decision on a worker's entitlement under section 192 itself.

In determining section 192 wage-loss benefits, the employment opportunity or opportunities should be available immediately or within the short-term, and the worker should have a reasonable chance of securing employment in a suitable occupation, should they choose to apply.

Where the Board and a worker are engaged in carrying out a rehabilitation plan, and all parties are cooperating in good faith, it is not required that temporary partial disability wage-loss benefits be based on short-term, temporary or lesser paying jobs that the worker could do, but which would be incompatible with the demands and commitment required to meet the overall vocational objective.

Permanent Partial Disability

A worker's entitlement to permanent partial disability benefits is considered under sections 195 and 196 of the *Act*. Entitlement under section 196 may require an employability assessment.

The goal is to identify suitable occupations, along with estimated earnings, that maximize the worker's long-term earning capacity up to the pre-injury wage rate. In most cases, "long-term" refers to three to five years.

The employability assessment process is conducted in light of all possible rehabilitation measures that may be of assistance and appropriate to the circumstances of each worker.

The rehabilitation plan may form the basis for the employability assessment. A functional capacity evaluation may be used to assess the worker's capacity for work. This provides information on the worker's residual maximum functional capabilities, confirmation of identified alternative job options and plans for vocational reintegration.

Labour market data in conjunction with the objective functional capacity information is used to create a residual vocational profile. A list of suitable occupations based on the profile is then produced. Consideration is then given to whether these occupations are reasonably available.

Where workers are given a copy of the assessment, they are allowed 30 days in which to respond. Unless this timeframe is waived by the worker, submissions received within this time frame are considered before the Board makes a decision on section 196 entitlement.

EFFECTIVE DATE:	January 1, 2024
AUTHORITY:	Sections 155, 192, and 196 of the *Act*.
CROSS REFERENCES:	Item C5-33.10, *Wage-Loss Benefits For Temporary Total Disability* (Section 3 From Temporary Total Disability to Temporary Partial Disability); Item C5-33.20, *Wage-Loss Benefits For Temporary Partial Disability* (Section 3, Amount of Compensation for Temporary Partial Disability Payment); Item C5-35.10, *Duty to Cooperate*; Item C5-35.20, *Duty to Maintain Employment*; Item C6-40.00, *Section 196 Permanent Partial Disability Benefits*; Item C11-89.10, *Vocational Rehabilitation – Income Continuity*, of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	January 1, 2024 – Consequential changes to reflect language updates to Chapter 5, *Wage-Loss Benefits and Return to Work Obligations*, and to implement Division 3.1 of the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41 of 2022). January 1, 2021 – Policy changes made consequential to implementing the permanent partial disability benefits provisions of the *Workers Compensation Amendment Act, 2020* (Bill 23). April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Policy updated to reflect the wording of the legislation and to remove outdated references to decision-makers, departments, appellate bodies and external agencies. November 1, 2002 − Reformatted and revised policy to set out the employability assessment process for temporary partial disability and permanent partial disability. Replaced policy items #89.00, #89.10, and #89.20 of the *Rehabilitation Services & Claims Manual,* Volume II. Applied to decisions made on or after November 1, 2002 on claims adjudicated under the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as amended by the *Workers Compensation Amendment Act, 2002*.
APPLICATION:	Applies to all decisions made on or after January 1, 2024

RE:	Vocational Rehabilitation − Income Continuity	ITEM:	C11-89.10

BACKGROUND

1. Explanatory Notes

This policy deals with the payment of a rehabilitation allowance pending the assessment of permanent partial disability compensation.

2. The Act

Section 155(1):

> To aid in getting an injured worker back to work or to assist in lessening or removing a resulting disability, the Board may take the measures and make the expenditures that the Board considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

Section 195(1):

> (1) Subject to section 196, if a permanent partial disability results from a worker's injury, the Board must
>
> (a) estimate the impairment of the worker's earning capacity from the nature and degree of the injury, and
>
> (b) pay the worker compensation that is a periodic payment of an amount that equals 90% of the Board's estimate of the worker's loss of average net earnings resulting from the impairment.

Section 196:

> (1) This section applies in relation to a permanent partial disability if an amount required under section 195 is less than an amount required under this section.
>
> (2) *Repealed*.
>
> (3) The Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the difference between
>
> (a) the average net earnings of the worker before the injury, and

(b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:

(i) the average net earnings that the worker is earning after the injury;

(ii) the average net *earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury*. (emphasis added)

POLICY

Continuity of Income Pending Assessment of Permanent Partial Disability Benefits

The Board may pay a rehabilitation allowance to assist workers who are not actively engaged in the rehabilitation process but who are awaiting assessment of their permanent disability benefits under section 196 of the *Act*. These payments will be considered for workers

- whose disability has stabilized,
- who are unemployed, or employed at a reduced income level due to their compensable disability,
- who are not entitled to wage-loss benefits,
- who are not receiving any other wage-loss equivalency benefits from the Board, and
- who are likely to receive permanent partial disability benefits under section 196 of the *Act*.

Prior to implementing an income continuity payment, the Board must have considered and offered to the worker all rehabilitation measures which are reasonable and might be of assistance to the worker.

Amount of Payment

Continuity of income payments are based initially on the same rate as the wage-loss benefit rate and will continue at that level until the permanent partial disability benefits are assessed under section 196 of the *Act*, except in any of the following circumstances:

1. The worker has retired.

2. The worker is experiencing non-compensable medical, psycho-social or financial problems which preclude active participation in the rehabilitation process.

3. The worker refuses to actively participate in the rehabilitation process.

In the above circumstances, the Board may complete an employability assessment under section 196, and may provide a copy of that assessment to the worker. Thirty days after the worker has been provided with a copy of the employability assessment, the Board will adjust the income continuity rate to the rate which best reflects the conclusions contained in the employability assessment regarding the worker's projected long-term earning capacity. However, the Board will not adjust the rate at this point if, during the 30-day period based on new evidence, the Board decides the employability assessment requires revision.

As part of the completion of the employability assessment and prior to adjusting the income continuity rate, the Board must investigate the worker's circumstances and must consider the impact of the compensable disability on the worker's decision to retire or not to participate in the rehabilitation process.

Permanent Disability Benefits Reopenings

Continuity of income payments will also be considered for workers who are already receiving permanent disability benefits on the claim, where the Board has reopened the permanent disability decision and it is likely that the worker will receive a significant increase in the worker's permanent disability rating. As well, there must be evidence of a deterioration in the worker's medical condition which is likely to be permanent, and the worker must be experiencing a reduction in income during the period which is related to the reasons for the reopening. Benefit levels will be established in accordance with this policy.

EFFECTIVE DATE:	January 1, 2021
AUTHORITY:	Sections 155 and 196 of the *Act*.
CROSS REFERENCES:	Item C6-40.00, *Section 196 Permanent Partial Disability Benefits*; Item C11-89.00, *Vocational Rehabilitation − Employability Assessments – Temporary Partial Disability and Permanent Partial Disability*, of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	January 1, 2021 – Policy changes made consequential to the permanent partial disability benefits provisions of implementing the *Workers Compensation Amendment Act, 2020* (Bill 23). April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

February 1, 2020 – Revised policy to update terminology and to clarify when income continuity benefits are considered.
June 1, 2009 – Deleted references to Board officers and Board officers in Vocational Rehabilitation Services.
March 3, 2003 - Amendments to reference a reopening of a permanent disability award, consequential to the *Workers Compensation Amendment Act (No. 2), 2002* (Bill 63 of 2002).
November 1, 2002 - Reformatted and revised policy to clarify that income continuity allowances will be considered for workers who are likely to receive a permanent partial disability award under then section 23(3) of the *Act*. Replaced policy items #89.11 and #89.13 of the *Rehabilitation Services & Claims Manual,* Volume II. Applied to decisions made on or after November 1, 2002 on claims adjudicated under the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as amended by the *Workers Compensation Amendment Act, 2002*.

APPLICATION: Applies to all decisions, including appellate decisions, made on or after January 1, 2021.

RE:	Vocational Rehabilitation − Vocational Assistance for Dependent Spouses and Dependants of Deceased Workers	ITEM:	C11-91.00

BACKGROUND

1. Explanatory Notes

This policy sets out vocational assistance that may be provided to spouses and dependants of deceased workers.

2. The Act

Section 155, in part:

> (2) If compensation is payable under this Part [Part 4 of the *Act* – Compensation to Injured Workers] as the result of the death of a worker, the Board may make provisions and expenditures for the training or retraining of a dependent spouse, regardless of the date of death.
>
> (3) The Board may, if it considers this advisable, provide counselling and placement services to dependants of a worker.

Section 168:

> (1) Subject to subsection (2), if compensation is payable as the result of the death of a worker or of injury resulting in such death, the Board must pay compensation to the dependants of the deceased worker in accordance with this Division [Division 5 of Part 4 of the *Act* – Compensation in Relation to Death of Worker].
>
> (2) Unless a shorter period applies under this Division, the Board must make periodic payments under this Division for the life of the person to whom the payment is to be made.

POLICY

Vocational Assistance for Dependent Spouses and Dependants of Deceased Workers

If a worker's death is compensable, the Board has statutory authority to provide counselling and placement services to the dependent spouse and other dependants. In addition, the Board has authority to make expenditures for the training of the dependent spouse. The Board takes the initiative in determining the need and extent of these services.

Sponsorship of Training for Dependent Spouses

The Board may offer training assistance to a dependent spouse where the training is designed to improve the spouse's earning capacity or effectiveness in the labour market generally.

Eligibility

1. Dependent spouses who receive compensation in relation to the death of a worker are eligible for training assistance.

2. Sponsorship of training will be considered for dependent spouses who were not employed at the time of the worker's death, or were employed in occupations with limited financial prospects. Dependent spouses employed in occupations with established career patterns at the time of the worker's death will not generally be considered for training assistance. Where the dependent spouse was in a career pattern prior to the marriage, and has the qualifications to return to that career pattern, the Board would not normally support training except where the qualifications required updating or upgrading to permit a return to that career pattern.

3. The dependent spouse's need for training will be a prime consideration in making a decision to sponsor a training program. This need will be assessed according to such factors as the length of time that the spouse has been out of the labour force, the impact of new technology on the dependent spouse's former occupation, and the financial impact of the worker's death on the household. If the dependent spouse has job-ready skills in an occupation that has reasonable prospects, training assistance will not normally be provided.

4. The dependent spouse's eligibility for training sponsorship may be considered regardless of the date of the worker's death. The Board would normally expect decisions under section 155(2) of the *Act* to be made

within a year of the death. Any request received after that time would not necessarily be denied, but the Board would be less likely to conclude that the training was needed as a result of the death.

Guidelines

1. Before agreeing to sponsor a specific training program, the Board should determine that the dependent spouse meets the entry requirements for the training program and has a reasonable prospect of completing the program successfully.

2. Assistance under section 155(2) of the *Act* is not limited to any particular kind of training, except that, to be consistent with the general policy and objectives of the *Act*, the program should be one that helps to improve the earning capacity of the dependent spouse. Thus, in one case, it may be a vocational training program for a particular occupation; in another case, it may be a training course designed to improve the effectiveness of the dependent spouse in the labour market generally.

3. With regard to a university or higher educational program, the Board may include this for support under section 155(2) where it appears to be needed to overcome the effect of the worker's death; but this would not involve support of a university program on an indefinite basis. Normally, the support would not extend further than one educational level beyond the qualifications that the dependent spouse has when the matter is considered.

4. For assistance to be rendered, it is not necessary that there should be any application. Assistance under section 155(2) may result from an application by the dependent spouse, or it may result from an initiative and proposal by the Board, or others concerned with the claim, with which the dependent spouse may agree.

5. The sponsorship opportunities of other agencies are considered in providing integrated service delivery, but their availability does not diminish the Board's primary service and funding responsibilities.

Expenditures

Sponsorship of formal training programs under section 155(2) of the *Act* will normally include payment of:

1. Tuition fees and necessary books, materials or equipment.

2. Travel costs and subsistence allowances, including temporary dependant care, as set out in Section 6 of Item C10-83.10, where appropriate.

3. Additional living expenses may be paid as follows:

   (a) The dependent spouse should not be expected to draw on savings or other capital sums while undertaking a program of training needed as a result of the worker's death.

   (b) The dependent spouse should be expected to use funds provided through a monthly periodic payment of compensation from the Board, Canada Pension Plan benefits, allowances from the department continued under the *Department of Employment and Social Development Act* (Employment and Social Development Canada – "ESDC"), etc., to meet ordinary living expenses while completing a training program. If the spouse's income from such sources falls below the minimum weekly level determined by the Board, the Board will normally authorize the payment of a living expenses allowance sufficient to raise the dependent spouse's income to the minimum rate of dependent spouse compensation. The allowance for living expenses is payable to the dependent spouse during the period required to complete the training program.

   (c) The minimum rate of dependent spouse compensation is equal to the weekly equivalent of 60% of 90% of the minimum average earnings prescribed by section 169 for calculating compensation payable to dependent spouses of deceased workers. This formula is essentially the same as is set out in section 169 for calculating the total compensation (including Canada Pension benefits) payable to a dependent spouse where there are no dependent children and the dependent spouse is either 50 years of age or older, or has a physical or mental disability that results in the spouse being incapable of earning.

   (d) Whether or not a dependent spouse's income falls below the minimum, the Board may supplement the income of the dependent spouse when the actual expenses incurred during the course of the program exceed what is covered by the above items.

Vocational Rehabilitation Services to Other Dependants of Deceased Workers

As long as no expenditures are involved, section 155(3) permits the Board to provide counselling and placement services to other dependants of deceased workers when the Board considers it advisable to make these services available.

EFFECTIVE DATE:	June 1, 2009
AUTHORITY:	Section 155 of the *Act*.
CROSS REFERENCES:	Item C8-56.00, *Compensation on the Death of a Worker – Calculation of Compensation – Dependent Spouse with Children*; Item C8-56.10, *Compensation on the Death of a Worker – Calculation of Compensation – Dependent Spouse with No Children*; Item C10-83.00, *Transportation*; Item C10-83.10, *Subsistence Allowances*.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted references to Board officers in Vocational Rehabilitation Services and updated reference to Human Resources and Skills Development Canada. December 31, 2003 – Consequential changes were made to this Item as a result of legislative changes to the manner in which survivor benefits were calculated under then section 17 of the *Act*. Those legislative changes were retroactive to June 30, 2002. November 1, 2002 – Reformatted and Revised policy. Replaced policy items #91.00 and #91.20 of the *Rehabilitation Services & Claims Manual,* Volume II. Applied to decisions made on or after November 1, 2002 on claims adjudicated under the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as amended by the *Workers Compensation Amendment Act, 2002*.
APPLICATION:	Applies on or after June 1, 2009.

RE: Responsibilities of Claimants **ITEM: C12-93.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on some of the roles and responsibilities of workers and dependants when making compensation claims.

2. The Act

Section 149:

(1) This section applies in relation to every occurrence of an injury or disabling occupational disease to a worker in an industry that is within the scope of the compensation provisions.

(2) As soon as practicable after the occurrence, the worker or, in the case of death, the worker's dependant must inform the employer of the occurrence as follows:

(a) the information provided must include

(i) the name of the worker,

(ii) the time and place of the occurrence, and

(iii) in ordinary language, the nature and cause of the injury or disease;

(b) the information must be provided to the superintendent, first aid attendant, supervisor or agent in charge of the work where the injury occurred or to another appropriate representative of the employer.

(3) In the case of an occupational disease, the employer who is to be informed under subsection (2) is the employer who last employed the worker in the employment in relation to which the occupational disease was due.

(4) On request of the employer, the worker must, if fit to do so, provide to the employer particulars of the injury or occupational disease on a form directed by the Board and supplied to the worker by the employer.

(5) Failure to provide the information required by this section is a bar to a claim for compensation under this Part [Part 4 – Compensation to Injured Workers and Their Dependants], unless the Board is satisfied that

(a) the information, although imperfect in some respects, is sufficient to describe the worker's injury or disease and the circumstances in which it occurred,

(b) the employer or the employer's representative had knowledge of the injury or disease, or

(c) the employer has not been prejudiced, and the Board considers that the interests of justice require that the claim be allowed.

POLICY

Policies in Chapter 12 relate to the roles and responsibilities of workers, employers, physicians, qualified practitioners, other persons authorized to provide health care, and the Board in the making and adjudicating of compensation claims.

A. REPORT TO EMPLOYER

Section 149(1) of the *Act* provides:

> This section applies in relation to every occurrence of an injury or disabling occupational disease to a worker in an industry that is within the scope of the compensation provisions.

Section 149(2) provides that as soon as practicable after the occurrence, the worker or, in case of death, the worker's dependant must inform the employer of the occurrence.

Where the worker's condition results from a series of injuries rather than just one injury, section 149(2) is complied with if the report to the employer is made as soon as practicable after the last injury in the series.

Pursuant to section 149(3), in the case of an occupational disease, the employer who is to be informed of the death or disablement is the employer who last employed the worker in the employment in relation to which the occupational disease was due.

Where the worker is a commercial fisher, the "employer" to whom the fisher must report is set out in section 10 of the *Fishing Industry Regulations*.

B. PROCEDURE FOR REPORTING

There is no requirement as to the form of the notice. It may be written or oral. However, section 149(4) of the *Act* provides that on the request of the employer, the worker must, if fit to do so, provide to the employer particulars of the injury or occupational disease on a form directed by the Board and supplied to the worker by the employer.

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 directed 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 directed 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 Employer's Report of Injury or Occupational Disease (described in Item C12-94.00), 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.

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 the worker's responsibilities under the *Act*.

C. FAILURE TO REPORT

Section 149(5) of the *Act* provides that a "Failure to provide the information required by this *section is a bar to a claim for compensation . . ., unless the Board is satisfied that:*

(a) the information, although imperfect in some respects, is sufficient to describe the worker's injury or disease and the circumstances in which it occurred,

(b) the employer or the employer's representative had knowledge of the injury or disease, or

(c) the employer has not been prejudiced, and the Board considers that the interests of justice require that the claim be allowed."

The evidence may show that it was practicable for a worker to report the injury, mental disorder, or disease to the employer long before such a report was actually made. In such a case, there will be "Failure to provide the information required by this section" within the meaning of section 149(5).

D. MEDICAL TREATMENT AND EXAMINATION

The obligations of an injured worker to undertake medical treatment and examination are discussed in Item C10-73.00.

E. 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 Section 6 of the policy in Item C5-33.00 and the policy in Item C5-33.20.

EFFECTIVE DATE: Section A is effective March 18, 2003.
AUTHORITY: Section 149 of the *Act*.
CROSS REFERENCES: Item C5-33.00, *Introduction to Compensation For Temporary Disability*; Item C5-33.20, *Wage-Loss Benefits For Temporary Partial Disability*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY: December 1, 2025 – This policy resulted from the consolidation of former policy items #92.00, #93.00, #93.10, #93.11, #93.12, #93.30, and #93.40, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*.
January 1, 2024 – Housekeeping change to update internal cross references.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. The principles set out regarding an employer's obligations when completing a Form 7 were derived from *Workers' Compensation Board of British Columbia, W.C.B. News*, November – December 1975, 4.
March 18, 2003 – Deleted reference to the *Workers' Compensation Reporter* Decision No. 223.

RE: Application for Compensation **ITEM: C12-93.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the application process for claiming compensation under the *Act*.

2. The Act

Section 121:

For the purposes of the compensation provisions,

(a) a worker who is a minor has the capacity of a person who has reached 19 years of age, and

(b) no other person has a cause of action or right to compensation for the personal injury or disablement of the worker except as expressly provided in the compensation provisions.

Section 151:

(1) An application for compensation must

(a) be made on the form directed by the Board or prescribed by regulation, and

(b) be signed by the worker or the worker's dependant making the application.

(2) If the Board is satisfied that compensation is payable, it may be paid without an application.

(3) Except as provided in this section and section 152, no compensation is payable unless an application for compensation is filed, or a determination under subsection (2) of this section is made, within one year after the date of the worker's injury, mental disorder, death or disablement from occupational disease.

(4) The Board may pay the compensation provided under this Part [Part 4 – Compensation to Injured Workers and Their Dependants] if

(a) an application is not filed within the period referred to in subsection (3),

(b) the Board is satisfied that special circumstances existed that precluded filing within that period, and

(c) the application is filed within 3 years after the date referred to in subsection (3).

(5) The Board may pay the compensation provided under this Part [Part 4 – Compensation to Injured Workers and Their Dependants] for the period beginning on the date the Board receives an application for compensation if

(a) an application is not filed within the period referred to in subsection (3),

(b) the Board is satisfied that special circumstances existed that precluded filing within that period, and

(c) the application is filed more than 3 years after the date referred to in subsection (3).

Section 152:

(1) The Board may pay the compensation provided under this Part [Part 4 – Compensation to Injured Workers and Their Dependants] if

(a) the application for compensation arises from a worker's death or disablement due to an occupational disease,

(b) sufficient medical or scientific evidence was not available on the date referred to in section 151(3) 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 that sufficient medical or scientific evidence, as determined by the Board, became available to the Board.

(2) If, since July 1, 1974, the Board considered an application for compensation under the equivalent of this section or section 151 in respect of a worker's death or disablement from occupational disease, the Board may reconsider the application but must apply subsection (1) of this section in the reconsideration.

POLICY

A. INTRODUCTION

Where the Board receives a report that a worker has an injury, mental disorder, 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 Coverage, the application is made on a Form 6/7, Independent Operator's Application for Compensation and Report of Injury or Occupational Disease, but a Form 6 may also be used.

For applications for compensation in respect of non-traumatic hearing loss, reference should also be made to policy in Section D of Item C4-31.00. In the case of occupational diseases, reference should be made to policy in Item C4-26.00.

B. ADJUDICATION WITHOUT AN APPLICATION

In accordance with section 151(2) of the *Act*, the Board may pay all the compensation due on a claim without first receiving an application from the worker. However, the Board 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. Permanent disability benefits may result.
4. In Personal Coverage cases before wage-loss benefits are payable.
5. Where a preliminary determination under Item C12-96.10 is carried out.
6. In third-party and out-of-province cases.
7. Silicosis claims.
8. On fatal claims before compensation in relation to death of a worker can be paid. A decision on the acceptability of the claim and the payment of funeral expenses under section 166 and the lump-sum compensation under section 167 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. The Board can however exercise discretion if the circumstances warrant a deviation from this requirement.

The Board will not accept a claim and pay compensation if the worker indicates that the worker does not wish to claim.

C. SIGNATURE ON AN APPLICATION FOR COMPENSATION

Section 151(1)(b) of the *Act* provides that an application for compensation must be signed by the worker or the worker's dependant making the application. A teleclaim or online application submitted for compensation by the worker or the worker's dependant satisfies the requirement that an application be signed under section 151(1)(b).

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

If the worker has a condition which prevents the signing of an application, the Board may accept an application signed by someone on the worker's behalf. This might be an adult with a close personal attachment to the worker.

Pursuant to section 121, unless otherwise disabled, a worker under the age of 19 years can and should sign the application form.

EFFECTIVE DATE:	Section A is effective October 21, 2020. Section B is effective June 1, 2009. Section C is effective September 1, 2022.
AUTHORITY:	Sections 121, 151, and 152 of the *Act*.
CROSS REFERENCES:	Item C4-31.00, *Hearing Loss*, Section D; Item C7-49.00, *Incapacity of a Worker*; Item C12-93.11, *Time Allowed for Submission of Application,* of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	March 2, 2026 – Housekeeping change to update the term "Personal Optional Protection" to "Personal Coverage." December 1, 2025 – This policy resulted from the consolidation of former policy items #93.20, #93.23, and #93.25, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. September 1, 2022 – Amended to clarify online or teleclaim applications satisfy legislative requirements. Housekeeping changes to update language. October 21, 2020 – Amended to reflect amendment to limitation period provision in the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted references to Board officer. March 3, 2003 – Amended to reference preliminary determinations under former policy item #96.21.
APPLICATION:	Section A applies on or after October 21, 2020. Section B applies on or after June 1, 2009. Section C applies to all decisions made on or after September 1, 2022.

RE: Time Allowed for Submission of Application **ITEM: C12-93.11**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on when a worker, or worker's dependants, must apply for compensation.

2. The Act

Section 151:

(1) An application for compensation must

(a) be made on the form directed by the Board or prescribed by regulation, and

(b) be signed by the worker or the worker's dependant making the application.

(2) If the Board is satisfied that compensation is payable, it may be paid without an application.

(3) Except as provided in this section and section 152, no compensation is payable unless an application for compensation is filed, or a determination under subsection (2) of this section is made, within one year after the date of the worker's injury, mental disorder, death or disablement from occupational disease.

(4) The Board may pay the compensation provided under this Part [Part 4 – Compensation to Injured Workers and Their Dependants] if

(a) an application is not filed within the period referred to in subsection (3),

(b) the Board is satisfied that special circumstances existed that precluded filing within that period, and

(c) the application is filed within 3 years after the date referred to in subsection (3).

(5) The Board may pay the compensation provided under this Part [Part 4 – Compensation to Injured Workers and Their Dependants] for the period beginning on the date the Board receives an application for compensation if

(a) an application is not filed within the period referred to in subsection (3),

(b) the Board is satisfied that special circumstances existed that precluded filing within that period, and

(c) the application is filed more than 3 years after the date referred to in subsection (3).

Section 152:

(1) The Board may pay the compensation provided under this Part [Part 4 – Compensation to Injured Workers and Their Dependants] if

(a) the application for compensation arises from a worker's death or disablement due to an occupational disease,

(b) sufficient medical or scientific evidence was not available on the date referred to in section 151(3) 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 that sufficient medical or scientific evidence, as determined by the Board, became available to the Board.

(2) If, since July 1, 1974, the Board considered an application for compensation under the equivalent of this section or section 151 in respect of a worker's death or disablement from occupational disease, the Board may reconsider the application but must apply subsection (1) of this section in the reconsideration.

POLICY

A. GENERAL

A worker or worker's dependant must apply for compensation for an injury, mental disorder, death or disablement from occupational disease within the time limits set out in section 151 of the *Act*.

Compensation is not payable unless an application is filed within one year after the date of the worker's injury, mental disorder, death or disablement from occupational disease, unless an exception applies. This section is not complied with simply by reporting the injury, mental disorder, death or disablement from occupational disease to the first aid attendant or having it confirmed by witnesses.

For an injury, the date of injury is the date the worker experienced a physiological change subsequent to a work incident. A physiological change may result from a specific incident or a series of incidents occurring over a period of time.

For a mental disorder, the date of the worker's mental disorder is the date the worker experienced a psychological change subsequent to exposure to a work-related event(s) and/or stressor(s). A diagnosis of a mental disorder is not required to establish the date of psychological change.

Thus, the one year period for filing an application for compensation for an injury or mental disorder commences on the date of physiological change or psychological change respectively, which is not necessarily the same as the date of subsequent disablement.

In the case of occupational diseases, reference should be made to policy in Item C4-26.00.

B. APPLICATION MADE OUT OF TIME

Before an application for compensation can be considered on its merits, it must satisfy the requirements of sections 151 and 152 of the *Act*. It is important to distinguish between the decision on the merits of the claim and the decision made under section 151 or section 152, since the distinction may affect the rights of appeal which a person has to challenge the decision. A separate decision on the effect of section 151 or section 152 must always be reached on a claim.

The general effect of sections 151 and 152 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. Special circumstances must have existed that precluded the application from being filed within that period. "Precluded" in this situation means to have made difficult or otherwise hindered.

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 worker. Each of these two requirements of section 151(4)(b) 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 that precluded filing 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 worker'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 worker'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 worker did have an injury, mental disorder, death or disablement from occupational disease.

The following facts illustrate a situation where special circumstances were found to exist. The worker incurred a minor right wrist injury, which at the time caused no disablement from work and did not require the worker to seek medical attention. There was, therefore, no reason why the worker should claim compensation from the Board, nor any reason why the worker's doctor or employer should submit reports to the Board. It was not until two years later when the worker began to experience problems with the right wrist that the worker submitted a claim to the Board. It was only then that the worker was incurring monetary losses for which compensation might be appropriate.

Special circumstances may also include lack of awareness that an injury, mental disorder, or occupational disease might be work-related. If the nature, extent, or symptoms of the injury, mental disorder, or occupational disease preclude a worker from filing within the time period, this may also constitute special circumstances.

2. Discretion of the Board

Assuming the Board accepts that there were special circumstances that precluded the worker from submitting an application within the one-year period, the second requirement of section 151(4)(b) 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 151(4)(b) 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, mental disorder, death or disablement from occupational disease. Also significant will be whether there are witnesses or other persons to whom the worker reported the injury, mental disorder, death or disablement from occupational disease and from whom the worker sought treatment for it who are still able to provide accurate statements to the Board. The Board will not exercise its discretion under section 151(4) 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 worker'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 worker from submitting an application within the one-year period, the Board decided to exercise its discretion against allowing the worker'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 worker's complaints to such a minor injury two years before.

The exercise of the Board's discretion under section 151(4) 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, mental disorder, death or disablement from occupational disease in question occurred and whether it caused the worker'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 in this Section, it is always necessary, in any event, to separate the decision on the merits and the exercise of discretion under section 151(4).

EFFECTIVE DATE:	May 1, 2024
AUTHORITY:	Sections 151 and 152 of the *Act*.
CROSS REFERENCES:	Item C3-12.00, *Personal Injury*; Item C4-26.00, *"Date of Injury" for Occupational Disease*; Item C12-93.10, *Application for Compensation*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #93.21 and #93.22, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. May 1, 2024 – Policy amended to clarify the approach to determine the date of a worker's mental disorder for the purpose of commencing the time limit to apply for compensation. Policy amended to clarify special circumstances which may have precluded filing an application for compensation within the time limit. April 3, 2023 – Housekeeping changes consequential to implementing the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41). October 21, 2020 – Amended to reflect amendment to limitation period provision in the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. December 1, 2013 – Policy amended to clarify that then section 55 of the *Act* applied to claims for compensation of mental disorders under then section 5.1, in the same manner as it is applied to compensation for injuries under then section 5. June 1, 2009 – Deleted reference to Board officer. March 3, 2003 – Inserted new wording of then section 55(3.3) of the *Workers Compensation Act*, R.S.B.C. 1996, c 492.
APPLICATION:	Applies to all decisions, including appellate decisions, made on or after May 1, 2024.

RE: Obligation to Provide Information **ITEM: C12-93.20**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on a worker's obligation to provide information to the Board when applying for, or receiving, compensation, and in relation to the worker's return to, or continuation of, work.

2. The Act

Section 153:

(1) A worker who applies for or is receiving compensation under this Part [Part 4 – Compensation to Injured Workers and Their Dependants] must provide the Board with the information that the Board considers necessary to administer the worker's claim.

(2) If a worker fails to comply with subsection (1), the Board may reduce or suspend payments to the worker until the worker complies.

Section 154.2, in part:

…

(2) A worker must cooperate with an employer and the Board in the worker's early and safe return to, or continuation of, work by doing the following:

(a) subject to subsection (3), contacting the employer as soon as practicable after the worker is injured and maintaining communication with the employer;

(b) on request of the employer, assisting the employer to identify suitable work for the worker that, if possible, restores the full wages the worker was earning at the worker's pre-injury work;

(c) providing the Board with information the Board requires in relation to the worker's return to, or continuation of, work;

(d) any other thing required by the Board.

(3) The obligations referred to in subsections (1)(a) and (2)(a) do not apply if, having regard to all of the circumstances, contact and communication between the employer and the worker are likely to imperil or delay the worker's recovery.

…

(6) If a worker fails to comply with subsection (2), the Board may reduce or suspend payments of compensation to the worker until the worker complies.

POLICY

The Board operates under an inquiry system and as such, reasonable efforts are made to obtain information directly from the source. However, it is recognized that, in the course of administering a claim, the Board may have to rely on a worker to obtain relevant information.

Policy in Item C5-35.10 provides guidance regarding a worker's obligation to provide the Board with information the Board requires in relation to the worker's return to, or continuation of, work. Policy in this Item provides guidance regarding a worker's obligation to provide any other information the Board requires to administer the worker's claim.

A worker's obligation to provide information may arise at any time during the claim cycle. Necessary information includes, but is not limited to, information related to the worker's compensable disability, pre- and post-injury earnings, tax status and Canada Pension Plan disability benefits.

The Board will set a timeframe for the worker to provide the necessary information. The timeframe may vary depending upon the nature of the information requested. However, it should not extend past 30 days, except where the Board is satisfied that the worker is making best efforts to obtain the necessary information.

Where the Board requires information from a worker that it considers necessary to administer the worker's claim, notification must be provided in writing. Notification to the worker must specify:

- what information is required;
- the worker's obligation to provide the information;
- the timeframe for compliance; and
- the consequences for failing to comply.

The Board may reduce or suspend a worker's payments if, after providing written notification of the obligation to provide necessary information and the consequences of failing to comply, the worker:

- fails or refuses to supply the information within the specified timeframe; and
- does not have a valid reason for failing to comply.

If a worker has to obtain the information from a third party (e.g. the department continued under the *Department of Employment and Social Development Act* (Employment and Social Development Canada – "ESDC") or the agency continued under the *Canada Revenue Agency Act* (Canada Revenue Agency)), the Board must be satisfied that the worker failed to take all reasonable steps to acquire the information before determining that a worker has failed to comply.

The Board recognizes that, in the course of obtaining requested information from third parties, certain fees may be levied. In these cases, the Board will provide reimbursement for necessary and reasonable costs incurred by the worker.

When a worker fails to fulfill the obligation to provide information, the Board will determine whether there was a valid reason. Payments will not be reduced or suspended for non-compliance if there is a valid reason acceptable to the Board, such as a sudden illness or a death in the family.

Once the worker has fulfilled the obligation to provide information, the Board will restore payments for any period for which they were reduced or suspended.

This policy does not restrict the Board from pursuing all available courses of action in response to fraud or misrepresentation.

EFFECTIVE DATE:	January 1, 2024
AUTHORITY:	Sections 153 and 154.2 of the *Act*.
CROSS-REFERENCES:	Item C5-35.10, *Duty to Cooperate*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from former policy item #93.26, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. May 1, 2024 − Housekeeping change to update internal cross reference. January 1, 2024 − Policy changes made consequential to implementing Division 3.1 of the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41). April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Updated reference to then titled Human Resources and Skills Development Canada and Canada Revenue Agency.
APPLICATION:	Applies to all decisions made on or after January 1, 2024.

RE: Responsibilities of Employers **ITEM: C12-94.00**

BACKGROUND

1. Explanatory Notes

This policy sets out the roles and responsibilities of employers in relation to reporting injuries, disabling occupational diseases, and deaths to the Board and providing required information.

2. The Act

Section 150:

(1) Subject to subsection (7), an employer must report to the Board, within 3 days after its occurrence, every injury to a worker that is or is claimed to be an injury arising out of and in the course of the worker's employment.

(2) Subject to subsection (7), an employer must report to the Board, within 3 days after receiving information under section 149 [Worker obligation to give notice of injury or disease to employer], every disabling occupational disease or claim for or allegation of an occupational disease in relation to a worker.

(3) An employer must report immediately to the Board the death of a worker if the death is or is claimed to be a death arising out of and in the course of the worker's employment.

(4) A report under this section must be on the form directed by the Board and must provide the following information:

(a) the name and address of the worker;

(b) the time and place of the injury, disease or death;

(c) the nature of the injury or alleged injury;

(d) the name and address of any physician or qualified practitioner who attended the worker;

(e) any other particulars required by the Board or by the regulations.

(5) A report under this section may be made by mailing copies of the form addressed to the Board at the address specified by the Board.

(6) An employer who fails to make a report required under this section commits an offence unless excused by the Board on the ground that the report, for some sufficient reason, could not have been made.

(7) Without limiting the authority of the Board under section 237 *[additional authority for orders, directives, rules and regulations]*, the Board may make regulations as follows:

(a) establishing a category of minor injuries not required to be reported under this section;

(b) establishing or varying the time at which the obligation to report under this section begins.

(8) If a report required under this section is not received by the Board within 7 days after an injury or death, or any other time prescribed by regulation under subsection (7), the Board

(a) may make an interim adjudication of the claim, and

(b) if the Board allows the claim on an interim basis, may begin the payment of compensation in whole or in part.

3. Reports of Injuries Regulations

Section 2:

A reportable injury is an injury arising out of and in the course of a worker's employment to which the compensation provisions of the *Workers Compensation Act* apply, or which is claimed by the worker concerned to have arisen out of and in the course of such employment, and in respect of which any one of the following conditions is present or subsequently occurs:

(a) the worker loses consciousness following the injury;

(b) the worker is transported or directed by a first aid attendant or other representative of the employer to a hospital or other place of medical treatment, or is recommended by such person to go to such place;

(c) the injury is one that obviously requires medical treatment;

(d) the worker states an intention to seek medical treatment;

(e) the worker has received medical treatment for the injury;

(f) the worker is unable or claims to be unable by reason of the injury to return to the worker's usual job function on any working day subsequent to the day of injury;

(g) the injury or accident resulted or is claimed to have resulted in the breakage of an artificial member, eyeglasses, dentures or a hearing aid;

(h) the worker or the Board has requested that an employer's report be sent to the Board.

Section 3:

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 section 2, or when notification of any such condition is received by mail or telephone at the local or head office of the employer.

POLICY

A. REPORT TO THE BOARD

Subject to policy in Sections C and D of this Item, section 150(1) of the *Act* provides that an employer must report to the Board, within three days after its occurrence, every injury to a worker that is or is claimed to be an injury arising out of and in the course of the worker's employment.

Subject to policy in Sections C and D of this Item, section 150(2) provides that an employer must report to the Board, within three days after receiving information under section 149, every disabling occupational disease or claim for or allegation of an occupational disease in relation to a worker.

Section 150(3) provides that an employer must report immediately to the Board the death of a worker if the death is or is claimed to be a death arising out of and in the course of the worker's employment.

The application of the above provisions to claims by commercial fishers is discussed in sections 4 and 10 of the *Fishing Industry Regulations*.

B. FORM OF REPORT

The report must be on the form directed by the Board and must provide the following information:

1. the name and address of the worker;
2. the time and place of the injury, disease 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.

The report may be made by mailing copies of the form addressed to the Board at the address specified by the Board.

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

Form 7	Employer's Report of Injury or Occupational Disease
Form 9	Employer's Statement of Return to Work (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 worker.

C. WHAT INJURIES MUST BE REPORTED

If none of the conditions listed (a) through (h) in Section 2 of the *Reports of Injuries Regulations* are present, an injury is a minor injury and is not required to be reported to the Board, unless one of those conditions subsequently occurs.

D. COMMENCEMENT OF THE OBLIGATION TO REPORT

Section 3 of the *Reports of Injuries Regulations* provides that 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 section 2 of the Regulations, or when notification of any such condition is received by mail or telephone at the local or head office of the employer.

An employer who protests a claim should take care not to delay the submission of the Form 7 Employer's Report of Injury or Occupational Disease 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.

E. ADJUDICATION AND PAYMENT WITHOUT EMPLOYER'S REPORT

An employer is always given an adequate opportunity to submit a Form 7 Employer's Report of Injury or Occupational Disease before a claim is adjudicated in its absence. If a claim is adjudicated without a Form 7 and then, after adjudication to allow and pay the claim, the employer's report is received objecting to the acceptability of the claim, the Board will investigate any of the matters raised in the objection. If, following investigation the Board is satisfied that the claim was properly accepted, the employer will be advised of the details and informed of the relevant rights of review and/or appeal. Payments to the worker will be continued during the investigation unless there is evidence suggesting fraud. If, following an investigation:

- within 75 days of when the decision on the claim was made, the Board is satisfied that the claim should not have been accepted based on applicable law and policy, and the merits and justice of the case, the Board may reconsider the decision under section 123(1) of the *Act*; or

- after 75 days of when the decision on the claim was made, where the Board is satisfied the decision contains an obvious error or omission, the Board may reconsider the decision under section 123(3) of the *Act*.

EFFECTIVE DATE:	Section A is effective October 21, 2020. Section E is effective October 29, 2020.
AUTHORITY:	Section 150 of the *Act*. Sections 2 and 3 of the *Reports of Injuries Regulations*, B.C. Reg. 713/74.
CROSS-REFERENCES:	Item C14-103.01, *Changing Previous Decisions – Reconsiderations*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #94.00, #94.10, #94.11, #94.12, #94.13, and #94.14, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. October 29, 2020 – Amended to reflect amendments to reconsideration provision in the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020. October 21, 2020 – Amended to reflect amendment to employer's reporting obligations provision in the *Act* by the *Workers Compensation Amendment Act*, 2020 (Bill 23 of 2020), in effect August 14, 2020. September 1, 2020 – Housekeeping change to correct the title of *Reports of Injuries Regulations*, B.C. Reg. 713/74. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted references to Board officer. March 18, 2003 – Deleted references to the *Workers' Compensation Reporter* Decision Nos. 223 and 224.

March 3, 2003 – Inserted references to review, appeal and reconsideration.

APPLICATION: Section A applies on or after October 21, 2020.
Section E applies on or after October 29, 2020.

RE: Employer Penalties for Failure to Report **ITEM: C12-94.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on penalties under the *Act* where an employer commits an offence by failing to report a worker's injury, disabling occupational disease, or death to the Board.

2. The Act

Section 150, in part:

…

(6) An employer who fails to make a report required under this section commits an offence unless excused by the Board on the ground that the report, for some sufficient reason, could not have been made.

…

(8) If a report required under this section is not received by the Board within 7 days after an injury or death, or any other time prescribed by regulation under subsection (7), the Board

(a) may make an interim adjudication of the claim, and

(b) if the Board allows the claim on an interim basis, may begin the payment of compensation in whole or in part.

Section 262:

(1) This section applies if the Board pays compensation under section 150(8) *[payment of compensation where employer defaults in reporting]*.

(2) If compensation is paid under section 150(8) before 3 days after the Board receives the report required by that section, that compensation may be levied and collected from the employer by way of additional assessment as a contribution to the accident fund, and payment may be enforced in the same manner as other assessments.

(3) If 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 this section.

POLICY

The maximum fine for committing an offence under section 150(6) of the *Act* is set out in Appendix 5 to this *Manual*.

The Board follows the following procedure for making interim adjudications on claims without employer reports, and levying corresponding assessments.

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 section 262 of the *Act*. 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 if an interim adjudication is made under section 150(8) accepting the claim, they will be charged with the full amount of costs incurred up to the elapse of three days after the Board receives their employer's report.

Prior to charging the cost of any particular claim to an employer under section 262(2), the Board 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 Board 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 worker 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 arrival of Form 7 Employer's Report of Injury or Occupational Disease, 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 worker 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 worker 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, vocational rehabilitation, and wage-loss benefits relating to the period in question, even if 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 term “preliminary determination” when it applies to the processing of payments on an apparently acceptable claim in the absence of some information which is likely to be delayed. The latter procedure is set out in policy in Item C12-96.10. The requirements of the preliminary determination procedure do not have to be met for an interim adjudication under section 150(8). 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 does arrive, it can be considered as evidence in making the final adjudication of the claim. The rules set out in policy in Item C12-96.10 regarding the non-recovery of payments made under a preliminary determination also apply here. If the employer’s report protests the acceptance of the claim, but the final adjudication is that it remains allowed, the employer will receive the usual notification of the relevant rights of review and/or appeal.

The above procedure applies to pay employer claims (see Section 3 of the policy in Item C5-34.10) and to employers with deposit accounts, but not to Personal Coverage or Federal Government claims.

Unless the Board receives the Form 7, the interim adjudication becomes the final decision on the acceptability of the claim and is subject to the provisions of section 123 of the *Act*.

If the Board receives the Form 7, the final adjudication becomes the final decision on the acceptability of the claim and is subject to the provisions of section 123.

The final adjudication does not constitute a reconsideration of the interim adjudication for the purpose of section 123. Section 150(8) contemplates that a final adjudication will be made, whenever the Form 7 is received.

EFFECTIVE DATE: October 29, 2020
AUTHORITY: Sections 150 and 262 of the *Act*.

CROSS REFERENCES:

Item C5-34.10, *Payment of Wage-Loss Benefits* (Section 3, Reimbursing Employers for Amounts Deducted from Compensation);
Item C12-94.00, *Responsibilities of Employers*;
Item C12-96.10, *Preliminary Determinations*;
Item C14-103.01, *Reconsiderations*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:

March 2, 2026 – Housekeeping change to update the term "Personal Optional Protection" to "Personal Coverage."
December 1, 2025 – This policy resulted from former policy item #94.15, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*.
January 1, 2024 – Housekeeping change to update internal cross reference.
October 29, 2020 – Amended to reflect amendments to reconsideration provision in the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
June 1, 2009 – Deleted references to Board officer.
March 3, 2003 – Inserted references to preliminary determination and the status of final adjudication for the purposes of then sections 96(4) and (5) of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492.
January 1, 1978 – the Board established a procedure for implementing then sections 54(7) and (8) (to make interim adjudications on claims without employer reports, and to levy assessments paid on these interim adjudications, against employers).

APPLICATION:

Applies on or after October 29, 2020.

RE:	Employer or Supervisor Must Not Attempt to Prevent Reporting	ITEM:	C12-94.20

BACKGROUND

1. Explanatory Notes

This policy sets out the provisions of the *Act* prohibiting claim suppression and provides guidance on related penalties for employers.

2. The Act

Section 73:

(1) 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 any of the following to the Board:

(a) an injury or allegation of injury, whether or not the injury occurred or is compensable under the compensation provisions;

(b) an illness, whether or not the illness exists or is an occupational disease compensable under the compensation provisions;

(c) a death, whether or not the death is compensable under the compensation provisions;

(d) a hazardous condition or allegation of a hazardous condition in any work to which the OHS provisions apply.

(2) 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

(a) making or maintaining an application for compensation under the compensation provisions, or

(b) receiving compensation under the compensation provisions.

POLICY

The Board may impose an Occupational Health and Safety (OHS) administrative penalty if it is determined that an employer has violated section 73 of the *Act*. The general criteria for calculating OHS administrative penalties are provided in the *Prevention Manual* in Item P2-95-5.

Item P2-95-5 also provides for the recovery of potential or actual benefits obtained from non-compliance.

As an alternative to imposing an OHS administrative penalty, the Board may refer the case to Crown Counsel for consideration of prosecution.

EFFECTIVE DATE:	January 1, 2024
AUTHORITY:	Section 73 of the *Act*.
CROSS REFERENCES:	Item P2-95-5, *OHS Penalty Amounts*, of the *Prevention Manual*.
HISTORY:	December 1, 2025 – This policy resulted from former policy item #94.20, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. January 1, 2024 – Policy changes made consequential to implementing Division 3.1 of the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41). November 24, 2022 – Housekeeping changes consequential to implementing the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41). April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. March 1, 2016 – Consequential housekeeping amendments made to reflect changes to then Item D12-196-6, the *OHS Penalty Amounts*, of the *Prevention Manual*, which became effective March 1, 2016.
APPLICATION:	Applies to all decisions made on or after January 1, 2024.

RE:	Responsibilities of Physicians and Qualified Practitioners	ITEM:	C12-95.00

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the responsibilities of physicians, qualified practitioners, and other people authorized to provide health care under the *Act*, such as submitting reports and providing assistance to workers.

2. The Act

Section 1, in part:

…

"physician" means a medical practitioner;

…

"**qualified practitioner**" means

(a) a nurse practitioner, or

(b) a person who is authorized under the *Health Professions and Occupations Act* to practise the designated health profession of chiropractic, dentistry, naturopathic medicine or podiatry;

…

"specialist" means a physician who

(a) resides and practises in British Columbia, and

(b) is recognized as having specialist qualifications by the regulator that is responsible, under the *Health Professions and Occupations Act*, for governing the designated health profession of medicine;

…

Section 163(1):

A physician or qualified practitioner attending or consulted on a case of injury to a worker in an industry within the scope of the compensation provisions, or of an alleged case of such an injury, has the following duties:

(a) to provide the reports in respect of the injury in the form required by regulation or directed by the Board, with the first report containing all requested information being provided to the Board within 3 days after the date of the physician's or qualified practitioner's first attendance on the worker;

(b) to provide a report to the Board within 3 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, to provide further adequate reports to the Board;

(c) if the physician

(i) is a specialist whose opinion is requested by the attending physician, the worker or the Board, or

(ii) continues to treat the worker after the physician is consulted as a specialist,

to provide the first report to the Board within 3 days after the consultation is completed and, if the physician is regularly treating the worker, to provide further reports to the Board as required in paragraphs (a) and (b);

(d) without charge to the worker, to give to the worker and the worker's dependants all reasonable and necessary information, advice and assistance they need to

(i) make an application for compensation, and

(ii) provide the certificates and proofs required in relation to the application.

Section 164, in part:

(1) Physicians, qualified practitioners or other persons authorized to provide health care under the compensation provisions must confine their treatment to injuries that are injuries to the parts of the body that they are authorized to treat under the Act under which they are permitted to practise.

…

(3) A person referred to in subsection (1) who fails to submit prompt, adequate and accurate reports and accounts as required by this Act or by the Board commits an offence.

(4) If a person fails to submit reports and accounts as referred to in subsection (3), the Board may

(a) cancel the right of the person to be selected by a worker to provide health care, or

(b) suspend the person for a period determined by the Board.

(5) If the right of a person to provide health care is cancelled or suspended under subsection (4),

(a) the Board must

(i) notify the person of the cancellation or suspension, and

(ii) inform the applicable regulator under the *Health Professions and Occupations Act*, and

(b) the person must notify injured workers who seek treatment from that person of the cancellation or suspension.

…

POLICY

A. INTRODUCTION

Section 163(1)(a) of the *Act* provides that it is the duty of every physician or qualified practitioner attending or consulted on a case of injury to a worker, in any industry within the scope of the compensation provisions of the *Act*, or of an alleged case of such an injury, to provide reports in respect of the injury in the form required by regulation or directed by the Board.

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

If treatment continues, progress reports must be provided.

Section 163(1)(b) provides that the physician or qualified practitioner must provide a report to the Board 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, to provide further adequate reports to the Board.

The duties described in Section A of this Item apply to a psychiatrist or psychologist who diagnoses a worker with a mental disorder under section 135(1)(b).

B. FORM OF REPORTS

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

Form 8/11 Physician's Report
Form 11A Physician's Invoice

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

All medical reports must be signed by the person making the report with reference to the professional designation of a partnership or clinic. A medical report submitted electronically in a form acceptable to the Board satisfies the requirement that medical reports be signed. Any change in status of a partnership or clinic, or change in its address, should be reported to the Board without delay to assure proper direction of payment.

C. REPORTS BY SPECIALIST

Section 163(1)(c) of the *Act* provides that if the physician is a specialist whose opinion is requested by the attending physician, the worker, or the Board, or if the physician continues to treat the worker after the physician is consulted as a specialist, the physician must provide the first report to the Board within three days after the consultation is completed and, if the physician is regularly treating the worker, the physician must provide further reports to the Board as required in paragraphs (a) and (b) of section 163(1).

D. FAILURE TO REPORT

Section 164(3) of the *Act* provides that physicians, qualified practitioners, or other persons authorized to provide health care under the compensation provisions of the *Act* who fail to submit prompt, adequate and accurate reports and accounts as required by the *Act* or by the Board commit an offence. If a person fails to submit such reports and accounts, section 164(4) provides that the Board may

(a) cancel the right of the person to be selected by a worker to provide health care, or

(b) suspend the person for a period determined by the Board.

If the right of a person to provide health care is cancelled or suspended, section 164(5)(a) provides that the Board must notify the person of the cancellation or suspension, and inform the applicable regulator under the *Health Professions and Occupations Act*.

Section 164(5)(b) provides that the person whose right to provide health care is cancelled or suspended must also notify any injured workers who seek treatment from that person of the cancellation or suspension.

The maximum fine for the offence committed under the *Act* is set out in Appendix 5 to this *Manual*.

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

E. PAYMENT OF WAGE-LOSS BENEFITS WITHOUT MEDICAL REPORTS

Wage-loss benefits are normally paid on the basis of medical evidence supporting a disability. This medical evidence is usually in the form of a signed medical report from a physician or a qualified practitioner.

Exceptions can be made in cases of short-term disability where the worker receives brief treatment from a first aid attendant or a hospital emergency department. If the circumstances are in all other respects acceptable, and the facts support the conclusion that the inability to earn full wages was a result of the injury, then wage-loss benefits may be paid. Normally, wage-loss benefits should not be paid for periods of disability exceeding three days or in any case of occupational disease unless supported by proper medical evidence.

Exceptions can also be made in cases of longer term disability. Where there is evidence to support the existence of a disability, but there has been no receipt of a medical report and where the claim has been adjudicated and accepted, a first payment should be processed on the claim. Moreover, there must be some discretion to depart from the principle that wage-loss benefits are to be paid only on medical confirmation of disability. That confirmation may appear at the time the disability begins, some time during the disability or, in some cases, after it has ceased. The question is always whether the worker was disabled. The best evidence of that disability is almost always medical evidence, but on some occasions, evidence from the worker or from other sources may be sufficient to establish the existence and continuation of the disability.

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

The Board accepts reports received from nurses in remote locations as medical reports if there is no physician in the immediate area.

F. OBLIGATION TO ADVISE AND ASSIST WORKER

Section 163(1)(d) of the *Act* provides that the physician or qualified practitioner has the duty, without charge to the worker, to give all reasonable and necessary information, advice, and assistance they need to

(i) make an application for compensation, and

(ii) provide the certificates and proofs, required in relation to the application.

This duty applies to a psychiatrist or psychologist who diagnoses a worker with a mental disorder under section 135(1)(b).

EFFECTIVE DATE:	Sections A and F are effective December 31, 2003. Section B is effective September 1, 2022. Section D is effective October 21, 2020.
AUTHORITY:	Sections 1, 163, and 164 of the *Act*.
CROSS REFERENCES:	*Rehabilitation Services & Claims Manual*, Volume II: Item C10-75.00, *Health Care Accounts – General*; Item C10-76.00, *Physicians and Qualified Practitioners*; Item C10-77.00, *Other Recognized Health Care Professionals*.
HISTORY:	April 1, 2026 – Housekeeping changes resulting from the replacement of the *Health Professions Act* with the *Health Professions and Occupations Act*. December 1, 2025 – This policy resulted from the consolidation of former policy items #95.00, #95.10, #95.20, #95.30, #95.31 and #95.40, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. September 1, 2022 – Amended to clarify that electronic submission of medical forms meets reporting requirements. October 21, 2020 – Amended to reflect amendments to the *Act* by the *Workers Compensation Amendment Act*, 2020 (Bill 23 of 2020), in effect August 14, 2020. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. December 31, 2003 – This policy was amended to reflect the amendment of then section 5.1(1) of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492 and the introduction of then sections 5.1(2) to 4 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492.
APPLICATION:	Sections A and F apply to injuries on or after December 31, 2003. Section B applies to all decisions made on or after September 1, 2022. Section D applies on or after October 21, 2020.

RE: Policy of the Board of Directors **ITEM: C12-96.00**

BACKGROUND

1. Explanatory Notes

This policy sets out the provisions of the *Act* related to the adjudication of compensation claims and provides guidance on the policy of the board of directors.

2. The Act

Section 122, in part:

(1) Subject to sections 288 and 289 *[appeals to appeal tribunal]*, the Board has exclusive jurisdiction to inquire into, hear and determine all matters and questions of fact and law arising or required to be determined under the compensation provisions, 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.

(2) Without restricting the generality of subsection (1), the Board has exclusive jurisdiction to inquire into, hear and determine the following:

(a) whether a worker's injury has arisen out of or in the course of an employment within the scope of the compensation provisions;

(b) the existence and degree of a worker's disability by reason of an injury;

(c) the permanence of a worker's disability by reason of an injury;

(d) the degree of impairment of a worker's earning capacity by reason of an injury;

(e) the existence, for the purposes of the compensation provisions, of the relationship of a family member of a worker;

(f) the existence of dependency in relation to a worker;

(g) the amount of the average earnings of a worker for purposes of payment of compensation;

(h) whether a person is a worker, subcontractor, contractor or employer within the meaning of the compensation provisions;

(i) the amount of the average earnings of a worker, whether paid in cash or board or lodging or other form of remuneration, for the purpose of levying assessments;

(j) whether an industry or a part, branch or department of an industry is within the scope of the compensation provisions, and the class to which an industry or a part, branch or department of an industry within that scope should be assigned;

(k) whether a worker in an industry that is within the scope of the compensation provisions is within the scope of those provisions and entitled to compensation under those provisions.

…

Section 319:

The board of directors must set and revise as necessary the policies of the board of directors, including policies respecting occupational health and safety, compensation, rehabilitation and assessment.

Section 332:

An action may not be maintained or brought against the Board or a director, officer or employee of the Board in respect of any act, omission or decision

(a) that was within the jurisdiction of the Board, or

(b) that the Board, director, officer or employee believed was within the jurisdiction of the Board.

Section 340:

Proceedings by or before the Board must not be

(a) restrained by injunction, prohibition or other process or proceeding in any court, or

(b) removed by certiorari or otherwise into any court.

POLICY

Section 319 of the *Act* provides that the board of directors must set and revise as necessary the policies of the board of directors, including policies respecting occupational health and safety, compensation, rehabilitation and assessment. While Board officers and the Workers' Compensation Appeal Tribunal ("WCAT") may make decisions on individual cases, only the board of directors has the authority and responsibility to set the policies of the Board.

The board of directors' Bylaw re Policies of the Board of Directors, provides that as of February 11, 2003, the policies of the board of directors consist of the following:

(a) The statements contained under the heading "Policy" in the *Assessment Manual*;

(b) The *Occupational Safety and Health Division Policy and Procedure Manual*;

(c) The statements contained under the heading "Policy" in the *Prevention Manual*;

(d) The *Rehabilitation Services & Claims Manual* Volume I and Volume II, except statements under the headings "Background" and "Practice" and explanatory material at the end of each Item appearing in the new manual format;

(e) The *Classification and Rate List*, as approved annually by the board of directors;

(f) *Workers' Compensation Reporter* Decisions No. 1 – 423 not retired prior to February 11, 2003 (see Appendix 1); and

(g) Policy decisions of the former Governors and the former Panel of Administrators still in effect immediately before February 11, 2003.

The Bylaw further provides that after February 11, 2003, the policies of the board of directors consist of the documents listed above, amendments to policy in the policy manuals, any new or replacement manuals issued by the board of directors, any documents published by the Board that are adopted by the board of directors as policies of the board of directors, and all decisions of the board of directors declared to be policy decisions. As of December 31, 2003, the board of directors policies do not include the *Occupational Safety and Health Division Policy and Procedure Manual*. As of December 11, 2013, the board of directors' policies do not include any of *Workers' Compensation Reporter* Decisions No. 1 – 423.

The Bylaw also directs that in the event of a conflict between policies of the board of directors:

(a) If the policies were approved by the board of directors on the same date, the policy most consistent with the *Act* or Regulations is paramount.

(b) If the policies were approved on different dates, the most recently approved policy is paramount.

The Bylaw directs that the policies of the board of directors are published in print. It also states that the policies may also be published through an accessible electronic medium or in some other fashion that allows the public easy access to the policies of the board of directors.

The Bylaw provides that the Chair of the board of directors supervises the publication of the *Workers' Compensation Reporter.* It will include decisions of the board of directors and selected decisions of WCAT. It may also include key decisions of the Courts on matters affecting the interpretation and administration of the *Act* or other matters of interest to the community.

The Bylaw makes clear that WCAT decisions do not become policy of the board of directors by virtue of having been published in the *Workers' Compensation Reporter*. It states that WCAT decisions are published in the *Reporter* to provide guidance on the interpretation of the *Act*, the Regulations and Board policies, practices and procedures.

EFFECTIVE DATE:	March 3, 2003
AUTHORITY:	Sections 122, 319, 332, and 340 of the *Act*. BOD Resolution No. 2003/02/11-04.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #96.00 and #96.10, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. March 3, 2003 – Amended to reflect the new wording of then section 96(1) of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492. Deleted references to how policy is to be applied.
APPLICATION:	Applies to all decisions made on or after March 3, 2003.

RE: Preliminary Determinations **ITEM: C12-96.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on preliminary determinations and when they are made.

2. The Act

None.

POLICY

A preliminary determination on a claim will be made, to provide temporary financial relief to the worker until the Board receives the information necessary to make a decision on the validity of the claim, when the following conditions are present:

1. The worker appears to be currently disabled from work.
2. On the available evidence, it appears probable that the worker has a compensable injury or occupational disease, or at least it appears that the evidence is evenly weighted.
3. There is some significant delay in obtaining evidence necessary to arrive at a conclusion on the validity of the claim, and the Board 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 the worker. 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. (See Chapter 16.)
7. An application for compensation has been received.

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

When a preliminary determination is made, the following rules will apply:

1. Wage-loss benefits will be commenced, with an explanation to the worker, employer and attending physician.

2. Payments of wage-loss benefits under the preliminary determination will commence as of the date when the Board makes the determination. Arrears of wage-loss benefits for any time period prior to that date will not be paid until a decision on the validity of the claim is made, except that the Board may pay such arrears on a preliminary determination to the extent that this may be necessary to avoid hardship.

3. The Board will proceed to obtain the evidence necessary to reach a decision on the claim as soon as possible.

4. Health care benefit bills will not be paid under a preliminary determination. If a preliminary determination has been made on a claim 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 decision on the claim. This principle also applies with respect to other medical referrals, with the exception of a consultation with a specialist that may be paid on an investigation basis.

5. If a preliminary determination has been made on a claim and payment of wage-loss benefits has commenced, and subsequently a decision is made 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 Item C17-114.10.

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

A preliminary determination made in accordance with this policy is not a "decision" for the purposes of section 123 of the *Act*. Rather, it is a Board administrative action that is intended to provide temporary financial relief to the worker until the Board receives the information required in order to make a decision on the validity of a claim. However, once the Board receives the required information and makes a decision, that decision is subject to the provisions of section 123.

EFFECTIVE DATE: October 29, 2020

CROSS REFERENCES: Chapter 16 − *Third Party/Out-of-Province Claims*;
Item C17-114.10, *Investigation Costs*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY: December 1, 2025 – This policy resulted from former policy item #96.21, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*.
October 29, 2020 – Amended to reflect amendments to reconsideration provision in the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
June 1, 2009 – Deleted references to Board officer.
March 3, 2003 – Amended to clarify that a preliminary determination is made to provide temporary financial relief until the Board receives information. Addition of requirement that an application for compensation must have been received. Amendments substitute the term "preliminary determination" for “interim decision”. Addition of statements discussing the application of then section 96(5) of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492. Policy applied to all preliminary determinations made on or after March 3, 2003.

APPLICATION: Applies on or after October 29, 2020.

RE: Suspension of Claim **ITEM: C12-96.20**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on situations where claims may be suspended.

2. The Act

None.

POLICY

If a report is submitted to the Board simply for the record, and if 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 be marked “nothing to consider”.

If 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 Item C12-93.20 regarding a worker’s obligation to provide information).

If 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.
(See Items C16-112.10 and C17-115.10.)

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

(1) if the worker leaves British Columbia without notifying the Board or receiving prior consent from the Board (see Item C10-72.00);

(2) if the worker is being paid full salary by the Federal Government (see Section 3 of the policy in Item C5-34.10);

(3) if the worker refuses to accept the cheques; and

(4) if a worker moves and the worker’s whereabouts are unknown.

If 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.

CROSS REFERENCES:

Item C5-34.10, *Payment of Wage-Loss Benefits* (Section 3, Reimbursing Employers for Amounts Deducted from Compensation);
Item C10-72.00, *Health Care – Introduction*;
Item C12-93.20, *Obligation to Provide Information*;
Item C16-112.10, *Entitled to Compensation Outside British Columbia*;
Item C17-115.10, *Interjurisdictional Agreements*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:

December 1, 2025 – This policy resulted from former policy item #96.22, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*.
January 1, 2024 – Housekeeping change to update internal cross reference.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

RE:	Permanent Disability Benefits Decision-Making Procedures	ITEM:	C12-96.30

BACKGROUND

1. Explanatory Notes

This policy sets out procedures for making decisions about permanent disability benefits.

2. The Act

Section 194:

(1) Subject to subsection (2), if a permanent total disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the worker's average net earnings.

(2) Compensation to be paid under this section must not be less than $2 174.27 per month.

Section 195:

(1) Subject to section 196, if a permanent partial disability results from a worker's injury, the Board must

(a) estimate the impairment of the worker's earning capacity from the nature and degree of the injury, and

(b) pay the worker compensation that is a periodic payment of an amount that equals 90% of the Board's estimate of the worker's loss of average net earnings resulting from the impairment.

(2) The minimum compensation to be paid under this section must be calculated in accordance with section 191(2) *[compensation for temporary total disability]* but to the extent only of the permanent partial disability.

(3) The Board may compile a rating schedule of percentages of impairment of earning capacity for specified injuries or mutilations that may be used as a guide in determining the compensation payable in permanent partial disability cases.

Section 196, in part:

(1) This section applies in relation to a permanent partial disability if an amount required under section 195 is less than an amount required under this section.

…

(3) The Board must pay the worker compensation that is a periodic payment of an amount that equals 90% of the difference between

(a) the average net earnings of the worker before the injury, and

(b) whichever of the following amounts the Board considers better represents the worker's loss of earnings:

(i) the average net earnings that the worker is earning after the injury;

(ii) the average net earnings that the Board estimates the worker is capable of earning in a suitable occupation after the injury.

POLICY

The Board determines whether an actual or potential permanent disability is accepted on a claim.

If the Board has accepted an actual or potential permanent disability, the Board then determines the extent of the disability and the worker's permanent disability benefit entitlement. This requires a determination under section 194, or sections 195 and 196 of the *Act.*

The Board may proceed to assess permanent disability benefits without a section 195(1) evaluation if there is sufficient medical evidence already available. Except for those cases, the normal practice is for a section 195(1) evaluation to be conducted for permanent disability benefits purposes by the Board or a Board-authorized External Service Provider (see Item C6-39.00).

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

The decision-making procedure for assessing entitlement to permanent disability benefits for psychological impairment under section 195(1) is discussed in Item C6-39.00.

In those cases where the worker has a section 195(1) assessment, the Board is required to notify the worker indicating the results of the assessment, which may include the results of a section 195(1) evaluation, and the conclusions reached regarding entitlement to permanent partial disability benefits.

When the Board adjudicates requests for the commutation of permanent disability benefits, it may obtain input from Vocational Rehabilitation Services before making a decision.

EFFECTIVE DATE:	January 1, 2021
AUTHORITY:	Sections 194, 195, 196, and 339 of the *Act*.
CROSS REFERENCES:	Item C6-39.00, *Section 195 Permanent Partial Disability Benefits*; Item C11-89.00, *Vocational Rehabilitation – Employability Assessments – Temporary Partial Disability and Permanent Partial Disability*; Item C12-97.40, *Evidence – Other Matters*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from former policy item #96.30, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. January 1, 2021 – Policy changes made consequential to implementing the permanent partial disability benefits provisions of the *Workers Compensation Amendment Act, 2020* (Bil 23). April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Inserted reference that a Board officer determines whether an actual or potential disability is accepted on the claim. Deleted references to Board officer in Disability Awards, Medical Services and Consultant. October 1, 2007 – Revised to delete references to memos and memorandums. July 2, 2004 – Revisions to the role of Board officers applied to all decisions, including appellate decisions, made on or after July 2, 2004.
APPLICATION:	Applies to all decisions, including appellate decisions, made on or after January 1, 2021.

RE: Evidence – General **ITEM: C12-97.00**

BACKGROUND

1. Explanatory Notes

This policy sets out general principles related to evidence, including guidance on the standard of proof.

2. The Act

Section 339:

(1) The Board may consider all questions of fact and law arising in a case, but the Board is not bound by legal precedent.

(2) The Board must make its decision based on the merits and justice of the case, but in doing this the Board must apply the policies of the board of directors that are applicable in that case.

(3) If the Board is making a decision respecting the compensation or rehabilitation of a worker and the evidence supporting different findings on an issue is evenly weighted in that case, the Board must resolve that issue in a manner that favours the worker.

POLICY

The term "onus" or "burden of proof" refers to who has the obligation to prove an issue in question. The workers compensation system in British Columbia operates on an inquiry basis, rather than an adversarial basis, so there is no onus or burden of proof on the worker or employer. The Board gathers the relevant evidence and determines whether it is sufficiently complete and reliable to arrive at a sound conclusion with confidence. If not, the Board considers what other evidence might be obtained, and must take the initiative in seeking further evidence.

The term "standard of proof" refers to the level of certainty required to prove an issue in question. For decisions respecting the compensation or rehabilitation of a worker, the standard of proof under section 339(3) of the *Act* is "at least as likely as not." If, on weighing the available evidence, the disputed possibilities are evenly balanced then section 339(3) requires that the issue be resolved in a manner that favours the worker.

For other decisions, the standard of proof is the balance of probabilities. Balance of probabilities means "more likely than not."

It is important to distinguish between the standard of proof and the test for the issue in question, such as causation. For example, for a worker to be entitled to compensation for an injury, the worker's employment has to be of causative significance in the occurrence of the injury, which means more than a trivial or insignificant aspect of the injury. The standard of proof applies to this determination, so the question for the Board is whether it is "at least as likely as not" that the worker's employment was more than a trivial or insignificant aspect of the injury.

Although there is no burden of proof on the worker, the *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 Board.

It is therefore not uncommon to see that a claim will be denied when a worker, 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 worker's hindsight which would allow the Board 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 the evidence does not support a finding it is "at least as likely as not" that any activity at work was of causative significance in the reported condition, at or near the time alleged by the worker, it can fairly be said that causation has not been established. The worker has simply failed to present those fundamental facts which bring the provisions of the *Act* into play.

EFFECTIVE DATE:	February 1, 2020
AUTHORITY:	Sections 134 and 339 of the *Act*.
HISTORY:	December 1, 2025 – This policy resulted from former policy item #97.00, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Policy amended to provide guidance on the legal issues of standard of proof, evidence, and causation. June 1, 2009 – Deleted references to officer and Adjudicator.
APPLICATION:	Applies to all decisions made on or after February 1, 2020.

RE: Evidence Evenly Weighted **ITEM: C12-97.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on situations where evidence supporting different findings on an issue is evenly weighted as set out in section 339(3) of the *Act*.

2. The Act

Section 339(3):

> If the Board is making a decision respecting the compensation or rehabilitation of a worker and the evidence supporting different findings on an issue is evenly weighted in that case, the Board must resolve that issue in a manner that favours the worker.

POLICY

For decisions respecting the compensation or rehabilitation of a worker, the standard of proof under section 339(3) of the *Act* is "at least as likely as not."

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 worker has a disability, but the issue is whether it is one arising out of or in the course of the worker's employment. The essence of the complaint is often that if there is some possibility that the injury arose out of the worker's 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*. 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 339(3), the Board is required to decide an issue in a manner that favours the worker if it appears that "the evidence supporting different findings on an issue is evenly weighted in that case". This applies only if there is evidence of roughly equal weight for and against the claim. It does not come into play if the evidence indicates that one possibility is more likely than the other.

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 339(3) applies when "the evidence supporting different findings on an issue is evenly weighted in that case". However, if the evidence before the Board does not support a finding 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 the evidence is evenly weighted does section 339(3) apply.

EFFECTIVE DATE:	February 1, 2020
AUTHORITY:	Section 339 of the *Act*.
HISTORY:	December 1, 2025 – This policy resulted from former policy item #97.10, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Policy amended to provide guidance on the legal issues of standard of proof, evidence, and causation. March 3, 2003 – Updated to reflect the new wording of then section 99 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492.
APPLICATION:	Applies to all decisions made on or after February 1, 2020.

RE: Presumptions **ITEM: C12-97.20**

BACKGROUND

1. Explanatory Notes

This policy provides an overview of various statutory presumptions in the *Act* and sets out references to related policies.

2. The Act

None.

POLICY

There are statutory presumptions set out in the *Act* in favour of workers or dependants already discussed in earlier chapters. These are as follows:

(1) Section 134(3) provides that in cases where the injury is caused by accident, if the accident arose out of the worker's employment, unless the contrary is shown, it must be presumed that the injury occurred in the course of the worker's employment; and if the accident occurred in the course of the employment, unless the contrary is shown, it must be presumed that the injury arose out of that employment.
(See Item C3-14.20.)

(2) Section 135(2) provides that if a worker who is or has been employed in an eligible occupation:

- is exposed to one or more traumatic events arising out of and in the course of the worker's employment in that eligible occupation, and
- has a mental disorder that, at the time of the diagnosis under subsection 135(1)(b), is recognized in the manual referred to in subsection 135(1)(b) as a mental or physical condition that may arise from exposure to a traumatic event,

the mental disorder must be presumed to be a reaction to the one or more traumatic events arising out of and in the course of the worker's employment in that eligible occupation, unless the contrary is proved.
(See Item C3-24.10.)

(3) Section 137 provides that if, on or immediately before the date of the disablement, the worker was employed in a process or industry described in column 2 of Schedule 1 opposite the occupational disease that has resulted in the disablement, the occupational disease must be presumed to have been due to the nature of the worker's employment unless the contrary is proved. (See Section A of Item C4-25.20.)

(4) Subject to the exposure and date of first disability requirements of section 139(4), section 139(2) provides that if a worker is disabled as a result of a heart disease, and was employed as a firefighter on or immediately before the date of disablement from the heart disease, the heart disease must be presumed to be due to the nature of the worker's employment as a firefighter, unless the contrary is proved. (See Section B of Item C4-25.20.)

(5) Subject to the exposure and first date of disability requirements of section 139(4), section 139(3) provides that if a worker is disabled as a result of a heart injury, and was employed as a firefighter on or immediately before the date of disablement from the heart injury, the heart injury must be presumed to have arisen out of and in the course of the worker's employment as a firefighter, unless the contrary is proved. (See Section B of Item C4-25.20.)

(6) Subject to subsections (2) and (3), section 140(1) applies to a worker who is or has been a firefighter who contracts a primary site lung cancer or a disease prescribed by the *Firefighters' Occupational Disease Regulation*. It provides that the disease must be presumed to be due to the nature of the worker's employment as a firefighter unless the contrary is proved. (See Section B of Item C4-25.20 and B.C. Reg. 125/2009.)

(7) Section 143 applies to a deceased worker who, on the date of the worker's death, was under 70 years of age and had an occupational disease of a type that impairs the capacity of function of the lungs. It provides that if the death was caused by an ailment or impairment of the lungs or heart of non-traumatic origin, it must be conclusively presumed that the death resulted from the occupational disease. (See Item C4-29.20.)

(8) Section 144 applies if:

- a worker is an applicant, as defined in the *Emergency Intervention Disclosure Act*, who has obtained a testing order under that Act respecting a source individual, as defined in that Act,

- the worker has contracted a communicable disease prescribed for the purposes of the *Emergency Intervention Disclosure Act*,

- the worker came into contact with the bodily substance of the source individual in the course of the worker's employment, and

- test results obtained under the testing order indicated that the source individual is infected with a pathogen that causes a communicable disease contracted by the worker.

It provides that it must be presumed, unless there is evidence to the contrary, that the communicable disease of the worker is due to the nature of the worker's employment. (See Section B of Item C4-25.20.)

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

EFFECTIVE DATE:	July 23, 2018
AUTHORITY:	Section 339 of the *Act*.
CROSS REFERENCES:	Item C4-25.20, *Establishing Work Causation* (Section B. Additional Presumptions in the Workers Compensation Act), of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from former policy item #97.20, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. July 23, 2018 – Policy consequentially amended in accordance with changes to then section 5.1 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, resulting from the *Workers Compensation Amendment Act, 2018*, Bill 9 of 2018. May 1, 2017 – Added to policy a reference to the firefighters' presumption and communicable disease presumption provided in the *Act.*
APPLICATION:	Applies on or after July 23, 2018.

RE: Medical Evidence **ITEM: C12-97.30**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on medical evidence, including situations involving a conflict of medical opinion.

2. The Act

Section 339, in part:

…

(2) The Board must make its decision based on the merits and justice of the case, but in doing this the Board must apply the policies of the board of directors that are applicable in that case.

(3) If the Board is making a decision respecting the compensation or rehabilitation of a worker and the evidence supporting different findings on an issue is evenly weighted in that case, the Board must resolve that issue in a manner that favours the worker.

POLICY

A. INTRODUCTION

It is the responsibility of the Board to make all the decisions relating to the validity of a claim and to make all the decisions relating to compensation payments. This includes decisions relating to medical as well as other aspects of the claim.

This does not mean, of course, that a lay judgment is preferred to a medical opinion on a question of medical expertise. What it means is that the Board is responsible for the decision-making process, and for reaching the conclusions on the claim. But this will, of course, require an input of medical evidence, or sometimes other expert advice, on any issue requiring professional expertise.

In reaching conclusions on a medical question, the policy is set out in this Item.

B. MATTER REQUIRING MEDICAL EXPERTISE

If 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 8/11 Physician's Report, or some information or opinion from the attending physician, or it might consist of advice provided from a Board Medical Advisor or another doctor. It is for the Board to decide when medical evidence is needed, what kind of medical evidence is needed, and on what questions.

C. STATEMENT OF WORKER ABOUT OWN CONDITION

A statement of a worker about the worker's own condition is evidence insofar as it relates to matters that would be within the worker's knowledge, and it should not be rejected simply by reference to an assumption that it must be biased. Also, there is no requirement that the statement of a worker about the worker's own condition must be corroborated. The absence of corroboration is, however, a ground for considering whether the worker should be interviewed by the Board, or telephone enquiries made, or whether anything relevant could be discovered by having the worker medically examined. A conclusion against the statement of the worker about the worker's own condition may be reached if the conclusion rests on a substantial foundation, such as clinical findings, other medical or non-medical evidence, or serious weakness demonstrated by questioning the worker, or if the statement of the worker relates to a matter that could not possibly be within the worker's knowledge.

D. STATEMENT BY LAY WITNESS ON MEDICAL QUESTION

A statement by a lay witness on a medical question may be considered as evidence if it relates to matters recognizable by a layperson; but not if it relates to matters that can only be determined by expertise in medical science. For example, a statement by a co-worker reporting they saw the worker bleeding from the forehead would be evidence of a head wound. On the other hand, a statement by a co-worker reporting they saw the worker with silicosis would be given no weight. Statements made by a first aid attendant or other categories of paramedical personnel can be considered insofar as they relate to matters within the normal experience or training of that category of paramedical personnel. But they must obviously be treated very cautiously if they go beyond that into areas requiring greater medical expertise, or if they conflict with the opinion of a doctor.

E. CONFLICT OF MEDICAL OPINION

If there are differences of opinion among doctors, or other conflicts of medical evidence, the Board must select from among them. The Board 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 Board

must analyze the opinions and conflicts as best as possible on each issue and arrive at its own conclusions about where the weight of the evidence lies. If it is concluded that there is doubt on any issue, and that the evidence supporting different findings on an issue is evenly weighted in that case, the Board must follow the mandate of section 339 of the *Act* and resolve that issue in a manner that favours the worker.
(See Item C12-97.10.)

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 Board will not simply select among them as a first step. The Board should first think about why they are different and consider whether the relevant non-medical facts have been clearly established. The Board may seek advice 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.

If 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 that 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. (See Item C10-73.00.)

F. TERMINATION OF BENEFITS

If a treating physician expresses an opinion that a worker is disabled from work by reason of a compensable disability, the Board may rely upon overall existing medical evidence from a doctor who has examined the worker or other substantive evidence on the file to reach a conclusion contrary to that opinion, or may decide to carry out further investigation which may involve a Board medical examination.

EFFECTIVE DATE:	Sections A, B, C, and F are effective June 1, 2009. Section E is effective February 1, 2020.
AUTHORITY:	Section 339 of the *Act*.
CROSS REFERENCES:	Item C10-73.00, *Direction, Supervision, and Control of Health Care*;

Item C12-95.00, *Responsibilities of Physicians and Qualified Practitioners*;
Item C12-97.10, *Evidence Evenly Weighted*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY:

December 1, 2025 – This policy resulted from the consolidation of former policy items #97.30, #97.31, #97.32, #97.33, #97.34, and #97.35, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
February 1, 2020 – Policy amended to provide guidance on the legal issues of standard of proof and evidence.
June 1, 2009 – Deleted references to officers, Claims Adjudicator, Claims Officer, Board Medical Advisor, Board physician, Disability Awards Officer and Adjudicator in Disability Awards.
March 3, 2003 – Inserted new wording of then section 99 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492.

APPLICATION:

Sections A, B, C, and F apply on or after June 1, 2009.
Section E applies to all decisions made on or after February 1, 2020.

RE: Evidence – Other Matters **ITEM: C12-97.40**

BACKGROUND

1. Explanatory Notes

This policy sets out evidentiary principles related to permanent partial disability benefits and to situations involving rumours, hearsay, and lies.

2. The Act

Section 195(1), in part:

> … if a permanent partial disability results from a worker's injury, the Board must
>
> (a) estimate the impairment of the worker's earning capacity from the nature and degree of the injury, …
>
> …

Section 339:

> (1) The Board may consider all questions of fact and law arising in a case, but the Board is not bound by legal precedent.
>
> (2) The Board must make its decision based on the merits and justice of the case, but in doing this the Board must apply the policies of the board of directors that are applicable in that case.
>
> (3) If the Board is making a decision respecting the compensation or rehabilitation of a worker and the evidence supporting different findings on an issue is evenly weighted in that case, the Board must resolve that issue in a manner that favours the worker.

POLICY

A. PERMANENT DISABILITY BENEFITS

The Board may proceed to assess permanent disability benefits without a section 195(1) evaluation, if there is sufficient medical evidence already available. Except for those cases, the normal practice is for a section 195(1) evaluation to be

conducted for permanent disability purposes by the Board or an External Service Provider.

It is the responsibility of the Board to classify the disability as a percentage of total disability. In doing this, it is proper for the Board to consider other factual and medical evidence as well as the section 195(1) evaluation report prepared by the Board or the External Service Provider. However, although the report of the Board or the External Service Provider is not the only medical input that the Board may use, it will usually be the primary input, and caution will be used in referring to any other medical opinion.

The section 195(1) evaluation report takes the form of expert evidence which, in the absence of other expert evidence to the contrary, should not be disregarded. It is always open to the Board to conclude that the worker's functional impairment is greater or less than the section 195(1) evaluation report indicates.

The decision-making procedure for assessing entitlement to permanent disability benefits for psychological impairment under section 195(1) of the *Act* is discussed in Item C6-39.00.

In making a determination under section 195(1), the Board will enquire carefully into all of the circumstances of a worker's condition resulting from a compensable injury.

B. RUMOURS AND HEARSAY

Hearsay must only be used very cautiously as evidence, and rumour must not be used as evidence at all. But even rumour is often valuable as a lead to investigation.

C. LIES

A lie may be ground for drawing an adverse inference with regard to the facts to which it relates. But it is not in itself ground for denying compensation, particularly when it relates to something not relevant to the claim at all.

EFFECTIVE DATE:	Section A is effective January 1, 2021.
AUTHORITY:	Sections 195 and 339 of the *Act*.
CROSS REFERENCES:	Item C12-97.00, *Evidence – General*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #97.40, #97.50, and #97.60, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. January 1, 2021 – Policy changes made consequential to implementing the permanent partial disability benefits provisions of the *Workers Compensation Amendment Act, 2020* (Bill 23). April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted references to officers in Disability Awards and officer.

January 1, 2003 – References to prior Subjective Complaints policy removed. Applied to new claims received and all active claims that were then awaiting an initial adjudication.

APPLICATION: Section A applies to all decisions, including appellate decisions, made on or after January 1, 2021.

RE: Surveillance **ITEM: C12-97.50**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the use of surveillance as a tool of last resort to gather evidence, as well as guidance about the treatment of surveillance evidence.

2. The Act

Section 122(1):

> Subject to sections 288 and 289 *[appeals to appeal tribunal]*, the Board has exclusive jurisdiction to inquire into, hear and determine all matters and questions of fact and law arising or required to be determined under the compensation provisions, 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.

Section 346:

> (1) If the Board considers that an inquiry is necessary, the inquiry may be made by an officer of the Board or by another person appointed by the Board to make the inquiry.
>
> (2) For the purposes of an inquiry under this section, the person making the inquiry has the powers conferred on the Board under section 342 *[authority to compel witnesses and production of evidence]*.

POLICY

Section 122 of the *Act* provides the Board with authority to investigate claims for compensation. Under section 346 of the *Act*, the Board has authority to make necessary inquiries and to appoint others to make such inquiries.

The Board is required to gather the evidence necessary to adjudicate claims, and surveillance is one method to obtain such evidence. Surveillance is the discreet observation of a worker, and includes video-recording, audio-recording, and photographing the worker.

The Board conducts surveillance and uses surveillance evidence in compliance with applicable legislation, including the *Freedom of Information and Protection of Privacy Act* and the *Canadian Charter of Rights and Freedoms*.

Surveillance is a tool of last resort to be used when determining if a worker has engaged in fraud or misrepresentation where there is other existing evidence of fraud or misrepresentation and a strong likelihood the surveillance evidence will assist in establishing the fraud or misrepresentation.

Director or Vice-President approval is required to approve surveillance requests.

Surveillance evidence is assessed by the Board for accuracy and relevancy to the issues being decided, and is considered in conjunction with all other evidence.

The worker is given a reasonable opportunity to view and respond to surveillance evidence before the Board finalizes any decision based on that evidence.

EFFECTIVE DATE:	March 1, 2019
AUTHORITY:	Sections 122 and 346 of the *Act.*
CROSS-REFERENCES:	Item C12-97.00, *Evidence - General*; Item C12-99.00, *Disclosure of Information*; Item C12-99.30, *Disclosure of Claim Files*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from former policy item #97.70, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. March 1, 2019 – Policy item added to address use of surveillance and treatment of surveillance evidence.
APPLICATION:	Applies on or after March 1, 2019.

RE: Investigation of Claims **ITEM: C12-98.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the investigation of claims, including the powers of the Board and the conduct of inquiries.

2. The Act

Section 122, in part:

(1) Subject to sections 288 and 289 *[appeals to appeal tribunal]*, the Board has exclusive jurisdiction to inquire into, hear and determine all matters and questions of fact and law arising or required to be determined under the compensation provisions, 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.

(2) Without restricting the generality of subsection (1), the Board has exclusive jurisdiction to inquire into, hear and determine the following:

(a) whether a worker's injury has arisen out of or in the course of an employment within the scope of the compensation provisions;

(b) the existence and degree of a worker's disability by reason of an injury;

(c) the permanence of a worker's disability by reason of an injury;

(d) the degree of impairment of a worker's earning capacity by reason of an injury;

(e) the existence, for the purposes of the compensation provisions, of the relationship of a family member of a worker;

(f) the existence of dependency in relation to a worker;

(g) the amount of the average earnings of a worker for purposes of payment of compensation;

(h) whether a person is a worker, subcontractor, contractor or employer within the meaning of the compensation provisions;

(i) the amount of the average earnings of a worker, whether paid in cash or board or lodging or other form of remuneration, for the purpose of levying assessments;

(j) whether an industry or a part, branch or department of an industry is within the scope of the compensation provisions, and the class to which an industry or a part, branch or department of an industry within that scope should be assigned;

(k) whether a worker in an industry that is within the scope of the compensation provisions is within the scope of those provisions and entitled to compensation under those provisions.

…

Section 341:

The Board may act

(a) on the report of any of its officers, and

(b) in relation to an inquiry under this Part [Part 8 – Workers' Compensation Board and General Matters], on the report of the person making the inquiry as to the result of that inquiry.

Section 342:

(1) The Board has the same powers as the Supreme Court

(a) to compel the attendance of witnesses and examine them under oath, and

(b) to compel the production and inspection of records and things.

(2) The Board may require depositions of witnesses residing in or out of British Columbia to be taken before a person appointed by the Board and in a manner similar to that established by the Rules of the Supreme Court for the taking of depositions in that court.

Section 346:

(1) If the Board considers that an inquiry is necessary, the inquiry may be made by an officer of the Board or by another person appointed by the Board to make the inquiry.

(2) For the purposes of an inquiry under this section, the person making the inquiry has the powers conferred on the Board under section 342 *[authority to compel witnesses and production of evidence]*.

Section 347:

(1) The Board, an officer of the Board or a person authorized by the Board for this purpose may examine the books and accounts of an employer and make any other inquiry the Board considers necessary to determine any of the following:

(a) whether an industry or person is within the scope of the compensation provisions;

(b) the amount of the payroll of the employer;

(c) whether a statement provided to the Board under section 245 *[employer to provide estimate of payroll]* is an accurate statement of the matters that are required to be stated in it.

(2) For the purpose of an inquiry under this section, the Board or person authorized to make the inquiry may give notice in writing to an employer or agent of an employer requiring the employer to bring or produce before the Board or person, at a time and place specified in the notice, all records in the possession, custody or power of the employer touching or in any way relating to or concerning the subject matter of the inquiry referred to in the notice.

(3) The time specified in a notice under subsection (2) must be at least 10 days after the notice is given.

(4) An employer or agent named in and served with a notice under subsection (2) must, at the time and place specified in the notice, produce all records in accordance with the notice.

(5) A person who does any of the following commits an offence:

(a) obstructs or hinders the making of an inquiry under this section;

(b) refuses to permit such an inquiry to be made;

(c) neglects or refuses to produce the required records at the time and place specified in the notice under subsection (2).

Section 348:

> An officer of the Board or a person authorized by the Board to make an inquiry under section 346 or 347 may
>
> (a) require and take affidavits, affirmations or declarations as to any matter of the inquiry,
>
> (b) take affidavits for the purposes of this Act, and
>
> (c) in relation to these, administer oaths, affirmations and declarations and certify that they were made.

POLICY

In the majority of claims the issues are decided by reference to the information received in the worker's application and the employer's and medical reports. Any insufficiency in the information is usually made good by telephone, correspondence, or by informal interview. In a minority of claims, a more formal inquiry, or medical examination, may be necessary.

A. POWERS OF THE BOARD

Section 342(1) of the *Act* provides the Board has the same powers as the Supreme Court

> (a) to compel the attendance of witnesses and examine them under oath, and
>
> (b) to compel the production and inspection of records and things.

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

Section 346(1) provides:

> If the Board considers that an inquiry is necessary, the inquiry may be made by an officer of the Board or by another person appointed by the Board to make the inquiry.

The Board has ruled that, for the purpose of Division 5 of Part 8 of the *Act* [Board Inquiry Powers] 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 the compensation provisions of the *Act*, appointed officers of the Board.

The maximum fine for committing an offence under section 347 of the *Act* is set out in Appendix 5 to this *Manual*.

B. MEDICAL EXAMINATIONS AND OPINIONS

The authority of the Board to require a worker to be medically examined is dealt with in Item C10-73.00.

The medical resources of the Board cannot be used to provide a medical opinion to anyone on request. The Board will, therefore, decline to provide a medical opinion if the request does not come from someone authorized to make the request. Those authorized are Board staff whose duties require an input of medical advice.

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.

C. 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 122 of the *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.

i. Place of Inquiry

For the purposes of claims adjudication, an officer of the Board may enter premises and make such inspections as considered necessary, notwithstanding that another agency may have inspection jurisdiction for accident prevention purposes. Where an inspection is of a technical nature and can only be carried out by someone technically qualified, perhaps an Occupational Hygiene Officer, such technical personnel may be used to make an inspection for the purposes of claims adjudication.

Where appropriate, the worker should be offered the opportunity to accompany the Board officer on the workplace visit.

ii. Failure of Worker to Appear

If the worker fails or refuses to appear at an inquiry, the worker's claim may be suspended, or decided in the worker's absence, or a further appointment may be arranged.

iii. Representation

A worker has a right to bring a representative to any enquiry, both at first instance and on appeal.

If the worker is unable to communicate effectively in English, an interpreter is arranged.

iv. Presence of Employer

If a worker is unrepresented, and the employer or employer's representative appears, it must be determined whether the employer is appearing on behalf of the worker. If the employer is appearing on behalf of the worker, the worker will be asked (but not in the presence of the employer) whether the worker has any objection to the employer being present. If there is no objection, the employer can be invited to attend the interview. If the worker does object, the employer will be asked to wait outside, and can be interviewed separately.

If appearing against the worker, the employer is not allowed to be present at the interview with the worker and must be interviewed separately. If there is any doubt as to the employer's intentions, the employer will be interviewed separately.

If a worker is represented, an employer may be permitted to be present even if the employer is appearing against the worker.

v. Oaths

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

If:

- 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 the witness' conscience; or

- the Board is satisfied that the form or manner of oath which a person called to give evidence declares to have a binding effect on the person's 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,

then section 20(3) of the *Evidence Act* directs that the person must, instead of taking an oath, make an affirmation.

An employer or representative or a worker's representative need not be placed under oath unless they have something specific or pertinent to contribute to the inquiry.

vi. Witnesses and Other Evidence

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

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

vii. Cross-examination

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

Cross-examination may, however, sometimes be permitted.

EFFECTIVE DATE:	Section A is effective March 3, 2003. Sections B and C.i are effective June 1, 2009.
AUTHORITY:	Sections 122, 341, 342, 346, 347, and 348 of the *Act*.
CROSS REFERENCES:	Item C15-109.00, *Advice and Assistance*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #98.00, #98.10, #98.11, #98.12, #98.13, #98.20, #98.21, #98.22, #98.23, #98.24, #98.25, #98.26, and #98.27, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. January 1, 2015 – Consequential amendments were made arising from changes to then Chapter 10, *Medical Assistance, Rehabilitation Services & Claims Manual*, Volume II. June 1, 2009 – Deleted references to Medical Advisor, officers, Adjudicators, and Claims Adjudicators. March 3, 2003 – Amended to reflect the new wording of then sections 87 and 88 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492. Deleted references to Review Division and Appeal Division.
APPLICATION:	Section A applies to all decisions made on or after March 3, 2003. Sections B and C.i apply on or after June 1, 2009.

RE: Disclosure of Information **ITEM: C12-99.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the disclosure of information by the Board and the provisions of the *Freedom of Information and Protection of Privacy Act*.

2. The Act

Section 235:

(1) If information in a claim file, or in any other material relating to the claim of an injured or disabled worker, is disclosed for the purposes of this Act by an officer or employee of the Board to a person other than the worker, that other person must not disclose the information except as follows:

(a) in compliance with an enactment of British Columbia or Canada;

(b) in compliance with a subpoena, warrant or order issued or made by a court, tribunal, person or body with jurisdiction to compel the production of information;

(c) for the purpose of preparing a submission or argument for a proceeding under a compensation provision, an OHS provision or Part 7 *[Appeals to Appeal Tribunal]*;

(d) if the information is about a person, the person has identified the information and consented, in the manner required by the Board, to disclosure of that information.

(2) A court, tribunal or other body may not admit into evidence any information that is disclosed in contravention of subsection (1).

(3) A person who contravenes subsection (1) commits an offence.

Section 271(1):

As soon as practicable after a request for a review is filed under section 270, the Board must provide the parties to the review with a copy of the Board's records respecting the matter under review.

Section 295, in part:

…

(2) As soon as practicable, the appeal tribunal must notify the Board of an appeal filed under this Part [Part 7 – Appeals to Appeal Tribunal].

(3) As soon as practicable after being given notice under subsection (2), the Board must provide the appeal tribunal and the parties to the appeal with a copy of the Board's records respecting the matter under appeal.

…

POLICY

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

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

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

Freedom of information and protection of privacy can be competing principles in many situations. Which principle is to be paramount in any particular case is sometimes difficult to determine. Until advised otherwise by the Information and Privacy Commissioner appointed under section 37 of *FIPPA*, openness prevails as far as possible in the area of compensation services. Exceptions to access should be narrowly construed. Since claim files deal with an identifiable individual, they contain personal and sensitive information. The privacy provisions of *FIPPA* will, therefore, prevail other than for the specific exceptions contained in *FIPPA*. Examples of such exceptions include the rights in section 3(6) of a party to a proceeding to access information, or the variety of exceptions listed in sections 33 and 33.1 such as the need to comply with the requirements of a specific enactment of British Columbia or Canada.

Sections 271 and 295 of the *Act* require a copy of records related to a matter under review or appeal to be provided to the parties to a review or appeal.

Section 3(6) of *FIPPA* states that the *Act* does not limit the information available by law to a party to a proceeding. A proceeding does not take place until either the worker or the employer has initiated a formal review or appeal.

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

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

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

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

EFFECTIVE DATE:	June 1, 2009
AUTHORITY:	Sections 235, 271, and 295 of the *Act*.
HISTORY:	December 1, 2025 – This policy resulted from former policy item #99.00, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. May 1, 2024 – Housekeeping changes consequential to implementing the *Freedom of Information and Protection of Privacy Amendment Act, 2021* (Bill 22), in effect November 25, 2021. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted references to Manager and Service Delivery Locations. March 3, 2003 – Reference added to the provision of copies of records related to a matter under review or appeal.
APPLICATION:	Applies on or after June 1, 2009.

RE: Disclosure of Issues Prior to Adjudication **ITEM: C12-99.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the disclosure of information before the validity of a claim has been adjudicated.

2. The Act

Section 353

(1) The workers' advisers, the employers' advisers and the staff of those advisers must have access at any reasonable time to the complete claims files of the Board and any other material relating to the claim of an injured or disabled worker.

(2) The advisers and staff referred to in subsection (1) must treat the information contained in the claims files as confidential to the same extent as the information is treated by the Board.

(3) An employers' adviser must not report or disclose to an employer information obtained from or at the Board of a type that would not be disclosed to the employer by the Board.

POLICY

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

As part of the investigation which precedes a decision to disallow a claim, the Board in virtually every case will have communicated with the worker. These communications may be by telephone, in person or in writing. Through the medium of these communications the worker is made aware of the nature of the problem and has an opportunity for input and comment. If, however, for some reason the Board concludes that a claim may not be acceptable, the worker is contacted before a decision is reached. The contact provides the worker with an opportunity for input and comment.

In situations involving serious cases or complex issues where no prior contact has been made with the worker, the details should be communicated in writing. Where this is done, the possibility of obtaining assistance from a union official or other adviser may be brought to the worker's attention.

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

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

EFFECTIVE DATE:	June 1, 2009
AUTHORITY:	Section 353 of the *Act*.
HISTORY:	December 1, 2025 – This policy resulted from former policy item #99.10, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted references to Adjudicator. January 1, 2005 – Housekeeping amendment to require written authorization for disclosure.
APPLICATION:	Applies on or after June 1, 2009.

RE: Notification of Decisions **ITEM: C12-99.20**

BACKGROUND

1. Explanatory Notes

This policy sets out how the Board communicates decisions to affected persons.

2. The Act

None.

POLICY

A. DEFINITIONS

A "decision" is a determination of the Board to give, deny, reconsider or limit entitlement to benefits and services, or impose or relieve an obligation, pertaining to compensation or rehabilitation matters under the compensation provisions of the *Act* or policy.

An "affected person" is a worker, dependant of a deceased worker, or an employer; or a person who claims to be an affected person, who is directly affected by a decision and may request a review or appeal of that decision.

B. COMMUNICATING DECISIONS

A decision is made, for the purpose of triggering the timelines for reconsiderations and reviews, on the date the decision is communicated to the affected person.

If the decision is communicated to affected persons on different dates, the statutory timelines commence on the date the decision is first communicated to an affected person.

The Board also communicates decisions to an affected person's advocate or representative if valid authorization is in place.

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

i. Written Communication

The Board will communicate the following decisions through a decision letter:

- Decisions on whether a claim is accepted, denied or rejected;
- Decisions on initial entitlement to wage-loss benefits, permanent disability benefits, dependant benefits, payments to a worker where the employer failed to comply with the obligations under the duty to maintain employment, and vocational rehabilitation assistance;
- Decisions on initial and long-term average earnings;
- Decisions that deny or limit benefits to a worker;
- Decisions regarding the re-opening of a matter previously decided;
- Decisions resulting from the reconsideration process;
- Decisions regarding the acceptance of a compensable consequence;
- Decisions that have been protested by the employer;
- Decisions on whether an employer may be granted a relief of costs; and
- Decisions to impose an administrative penalty on the employer for failure to comply with the duty to cooperate or duty to maintain employment.

The communication of the above decisions in writing triggers the timelines for reconsideration and review. The fact that a decision was not communicated in writing does not void the decision.

If one of the above decisions is not communicated in writing, the Board will determine whether the decision was satisfactorily communicated through other means, for example, verbally, through the payment or termination of compensation, or the referral of a worker for medical treatment or examination, in order to determine the timelines for reconsideration and review.

A decision letter will include an explanation of the relevant rights of review and/or appeal, and should, where appropriate, include the following elements:

1. The matter being adjudicated;
2. The evidence that was considered;

3. An explanation of the weight apportioned to the evidence and the reasons for the weighting;

4. Review of on-going communication with the worker where the relevant issues were discussed and details of the worker's response;

5. Reference to any relevant sections of the *Act* or Board policy;

6. The formal decision; and

7. An explanation of the impact of the decision on payment of compensation or entitlement to other benefits or services.

Decision letters are provided to persons directly affected by the decision.

Before a review or appeal is initiated, the type of information from a worker's claim that can be disclosed to the employer and/or authorized advocates and representatives is limited. Disclosure of personal and medical information is limited to information that is relevant to the claim and the issues involved, and that the employer has a need to know. The same approach applies for notification of decisions to health care providers, such as physicians and pharmacists.

If a decision is provided in writing and mailed to an affected person, the decision is deemed to have been communicated on the 8th day after it was mailed. Therefore, the reconsideration timeline starts at the end of the 8-day mailing period.

ii. Verbal and Other Communication

The Board may also communicate decisions such as health care decisions or administrative actions, verbally. Examples of the types of decisions the Board may communicate verbally include:

- a decision to approve an additional two weeks of physiotherapy benefits beyond the initial entitlement period; or

- a referral to a specialist.

When a decision is communicated verbally, an explanation of the rights of review and/or appeal will be verbally provided to the affected person. The verbal communication also should, where appropriate, include an explanation of the decision in accordance with the elements of a decision letter.

Documentation on the claim is sufficient evidence that verbal communication of the decision, including the reasons for the decision and notice of review and appeal rights, has occurred.

A copy of the written record of the decision is provided upon request following the verbal communication of a decision; however, it does not constitute a new decision. The statutory timelines for reconsiderations and reviews commence from the date of the verbal communication.

The Board may communicate decisions through the ongoing payment of temporary or permanent disability benefits, the payment of health care invoices, or the final payment of temporary disability or health care benefits, where the decision is uncontested and/or is in favour of the worker.

For example, if a claim is allowed for ongoing wage-loss benefits and there has been no protest from the employer, the Board does not provide a letter outlining the reasons for the continued payment of benefits.

C. FINDING OF FACTS

A finding of fact is not a decision. It is the factual basis on which a decision is made.

Findings of fact may change based on new information and are not subject to the limits on the Board's reconsideration authority.

A finding of fact may not be reviewed or appealed in the absence of an expressed or implied decision under review or appeal.

D. REJECTED CLAIMS

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

1. a self-employed worker has no Personal Coverage;

2. the worker was employed by an employer not covered under the *Act*;

3. a report was submitted in error. Normally, this occurs when a physician, on the basis of a misunderstanding, submits a report in error.

If a claim is rejected, notification of the review and/or appeal procedures is provided to the person making the claim.

EFFECTIVE DATE: January 1, 2024
AUTHORITY: Sections 123 and 319 of the *Act*.
HISTORY: March 2, 2026 – Housekeeping change to update the term "Personal Optional Protection" to "Personal Coverage."
December 1, 2025 – This policy resulted from former policy item #99.20, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*.

January 1, 2024 – Policy changes made consequential to implementing Division 3.1 of the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41).
October 29, 2020 – Amended to reflect amendments to reconsideration provision in the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
April 1, 2010 – Amended to provide a definition of decisions; clarify when a decision is made and how it is communicated; define a finding of fact; and confirm that rights of review and appeal are communicated on rejected claims.
June 1, 2009 – Deleted reference to “send a cheque” and replaced with “may make a payment”.
January 1, 2005 – Housekeeping amendment to require written authorization for disclosure, and to clarify appropriate disclosure principles.
March 3, 2003 – Inserted references to evenly weighted evidence and the rights of review and/or appeal.

APPLICATION: Applies to all decisions made on or after January 1, 2024.

RE: Notification of Decisions – Other Matters **ITEM: C12-99.21**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on how the Board deals with complaints about its decisions and how the Board notifies workers and employers about decisions on permanent disability benefits.

2. The Act

None.

POLICY

A. PROCEDURE FOR HANDLING COMPLAINTS OR INQUIRIES ABOUT A DECISION

The Board frequently receives letters, telephone calls and visits from workers, employers and their representatives concerning the decisions the Board makes 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.

If the worker or employer is requesting further explanation, this should be given. In the case of advocates and representatives, disclosure of information will only be provided if proper written authorization is in place. If, however, dissatisfaction is expressed with the substance of the decision, the policy outlined in Item C14-103.01 is followed. This policy 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.

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.

B. NOTIFICATION OF PERMANENT DISABILITY BENEFITS

When permanent disability benefits are granted, the letter advising of the compensation will include the permanent functional impairment evaluation report on which the benefits have been based. It will also contain the percentage rate of disability assessed. If the case is one of Proportionate Entitlement, the letter will state the nature and extent of the

pre-existing disability and the nature and extent of the further disability. A copy of the letter is sent to the employer. This letter will include information regarding the relevant rights of review and/or appeal.

Other than to the employer or the worker, the amount being paid per month for permanent disability benefits will only be disclosed to public or private agencies in accordance with the criteria for disclosure as set out in policy in Item C12-99.40.

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

EFFECTIVE DATE:	Section A is effective June 1, 2009. Section B is effective March 3, 2003.
CROSS REFERENCES:	Item C6-44.00, *Proportionate Entitlement*; Item C12-99.20, *Notification of Decisions*; Item C12-99.30, *Disclosure of Claim Files*; Item C12-99.40, *Disclosure to Public or Private Agencies*, of *the Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #99.22 and #99.24, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted references to officers and manager in the Compensation Services Division. January 1, 2005 – Housekeeping amendment to require written authorization for disclosure of information. March 3, 2003 – Inserted reference to Item C14-103.01 and deleted references to Review Board. Amended regarding references to review and appeal.
APPLICATION:	Section A applies on or after June 1, 2009. Section B applies to all decisions made on or after March 3, 2003.

RE: Disclosure of Claim Files **ITEM: C12-99.30**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the disclosure of claim files, including eligibility for disclosure.

2. The Act

Section 235:

(1) If information in a claim file, or in any other material relating to the claim of an injured or disabled worker, is disclosed for the purposes of this Act by an officer or employee of the Board to a person other than the worker, that other person must not disclose the information except as follows:

(a) in compliance with an enactment of British Columbia or Canada;

(b) in compliance with a subpoena, warrant or order issued or made by a court, tribunal, person or body with jurisdiction to compel the production of information;

(c) for the purpose of preparing a submission or argument for a proceeding under a compensation provision, an OHS provision or Part 7 *[Appeals to Appeal Tribunal]*;

(d) if the information is about a person, the person has identified the information and consented, in the manner required by the Board, to disclosure of that information.

(2) A court, tribunal or other body may not admit into evidence any information that is disclosed in contravention of subsection (1).

(3) A person who contravenes subsection (1) commits an offence.

Section 271(1):

As soon as practicable after a request for a review is filed under section 270, the Board must provide the parties to the review with a copy of the Board's records respecting the matter under review.

Section 295, in part:

…

(2) As soon as practicable, the appeal tribunal must notify the Board of an appeal filed under this Part [Part 7 – Appeals to Appeal Tribunal].

(3) As soon as practicable after being given notice under subsection (2), the Board must provide the appeal tribunal and the parties to the appeal with a copy of the Board's records respecting the matter under appeal.

…

Section 353:

(1) The workers' advisers, the employers' advisers and the staff of those advisers must have access at any reasonable time to the complete claims files of the Board and any other material relating to the claim of an injured or disabled worker.

(2) The advisers and staff referred to in subsection (1) must treat the information contained in the claims files as confidential to the same extent as the information is treated by the Board.

(3) An employers' adviser must not report or disclose to an employer information obtained from or at the Board of a type that would not be disclosed to the employer by the Board.

POLICY

A. INTRODUCTION

The claim file is the master file for recording information used in the adjudication and administration of a claim. Information may exist outside of the claim file. However, all evidence used in the adjudication of the claim is contained in the claim file. Medical opinions, as well as any further comments, are all recorded on, and become part of, the claim file.

Sensitive personal information that is received, which has not been specifically requested and which is not relevant to the adjudication or administration of the claim will not become part of the claim file. It will normally be destroyed. However, where the original document is still in the Board's possession, it will be returned to the sender when requested by the worker or sender.

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

B. ELIGIBILITY FOR DISCLOSURE

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

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

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

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

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

C. PROVISION OF COPIES OF FILE DOCUMENTS

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

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

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

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

No fees are charged to workers for the copy of their claim files. Fees are also not charged to employers for a copy of claim files where they are entitled to disclosure.

D. PERSONAL INSPECTION OF FILES

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

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

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

Explanations about what is in the file must be sought from the person or body dealing with the matter, a Workers' Adviser, an Employers' Adviser, or the person's own representative.

E. DISCLOSURE

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

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

If it is not a review or appeal situation, a worker may obtain disclosure from the Board. Where disclosure is available pursuant to the disclosure policies and it is desired simply to inspect the original file in person at an office of the Board, 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.

F. COMPLAINTS REGARDING FILE CONTENTS

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

decision on the merits of the claim or other matter. Where the person making the objection is the worker, anyone who had access to the file in the one-year period prior to the annotation to the record will be informed.

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

G. UNSOLICITED INFORMATION

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

If 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. If, 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. If, after investigation, the information is determined to be accurate, a final assessment as to relevancy will be made.

5. If 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. If 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. If 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 in Section F of this Item.

EFFECTIVE DATE: Sections A, D, and E are effective June 1, 2009.
Section B is effective March 3, 2003.
Section C is effective May 1, 1993.

AUTHORITY: Sections 235, 271, and 295 of the *Act*.

HISTORY: December 1, 2025 – This policy resulted from the consolidation of former policy items #99.30, #99.31, #99.32, #99.33, #99.34, #99.35, and #99.23, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
June 1, 2009 – Deleted references to Adjudicator, Board officers, physicians, Board Medical Advisors, Manager and Board staff. Deleted references to Client Service Managers of the appropriate Service Delivery Location and outside the Richmond area.
March 3, 2003 – Inserted reference to review. Amended regarding reference to review. Added provision for disclosure after request for review and after appeal filed to WCAT. Deleted reference to address where requests for disclosure must be submitted by employers and workers. Applied to all decisions made on or after March 3, 2003.

May 1, 1993 – Disclosure fees terminated for the provision of copies of assessment files, claims files, and occupational safety and health files to authorized persons for the purposes of appeals and certain other proceedings (see Governors' Decision No. 37 (1993) 9:3 *W.C.R.* 337.)

APPLICATION: Sections A, D, and E apply on or after June 1, 2009.
Section B applies to all decisions made on or after March 3, 2003.

RE: Disclosure to Public or Private Agencies **ITEM: C12-99.40**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the disclosure of information and claim files to public or private agencies, such as other Boards and the Government of Canada.

2. The Act

Section 235:

(1) If information in a claim file, or in any other material relating to the claim of an injured or disabled worker, is disclosed for the purposes of this Act by an officer or employee of the Board to a person other than the worker, that other person must not disclose the information except as follows:

(a) in compliance with an enactment of British Columbia or Canada;

(b) in compliance with a subpoena, warrant or order issued or made by a court, tribunal, person or body with jurisdiction to compel the production of information;

(c) for the purpose of preparing a submission or argument for a proceeding under a compensation provision, an OHS provision or Part 7 *[Appeals to Appeal Tribunal]*;

(d) if the information is about a person, the person has identified the information and consented, in the manner required by the Board, to disclosure of that information.

(2) A court, tribunal or other body may not admit into evidence any information that is disclosed in contravention of subsection (1).

(3) A person who contravenes subsection (1) commits an offence.

Section 332:

An action may not be maintained or brought against the Board or a director, officer or employee of the Board in respect of any act, omission or decision

(a) that was within the jurisdiction of the Board, or

(b) that the Board, director, officer or employee believed was within the jurisdiction of the Board.

Section 349:

(1) Officers of the Board and persons authorized to make an inquiry under this Division [Division 5 – Board Inquiry Powers] must not, except in the performance of their duties or under the authority of the Board, disclose or allow to be disclosed information obtained by them or which has come to their knowledge in making or in connection with an inquiry under this Division [Division 5 – Board Inquiry Powers].

(2) A person who contravenes subsection (1) commits an offence and is liable on conviction to a fine not greater than $6 689.64.

POLICY

A. INTRODUCTION

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

(a) Where an appropriate signed consent has been received from the worker.

(b) To any agency having statutory authority allowing access to personal information.

(c) To comply with a subpoena, warrant or order issued or made by a court, person or body with jurisdiction to compel the production of the information.

(d) To a member of the Legislative Assembly who has been requested by the worker to assist in resolving a problem.

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

B. LEGAL MATTERS

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

At the request of the Board's General Counsel, a Director or designate will be asked to respond to a subpoena or other request for information from a lawyer.

C. OTHER WORKERS COMPENSATION BOARDS

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

D. GOVERNMENT OF CANADA

In referring workers to a department of the Government of Canada for assistance in job placement, the Board may, with the worker's signed consent, furnish that department with a brief description of the worker's functional abilities and medical restrictions.

E. CANADA PENSION PLAN

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

The Freedom of Information and Protection of Privacy ("FIPP") Office of the Board handles requests from the Canada Pension Plan for information. Where the Board receives a request authorized by the worker or by statute, the FIPP Office provides the Canada Pension Plan with copies of documents specified in the request. Any charge for this service is paid by the Canada Pension Plan.

F. MINISTRY OF SOCIAL DEVELOPMENT AND POVERTY REDUCTION

If the Ministry of Social Development and Poverty Reduction has a debt owing to it, the Board will disclose to the Ministry the amount of any compensation being paid by the Board.

G. POLICE

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

H. GOVERNMENT EMPLOYEES COMPENSATION ACT

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

EFFECTIVE DATE:	Sections B, E, and F are effective June 1, 2009.
AUTHORITY:	Sections 235, 332, and 349 of the *Act*.
CROSS REFERENCES:	Item C7-48.00, *Assignments, Charges or Attachments of Compensation*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #99.50, #99.51, #99.52, #99.53, #99.54, #99.55, #99.56, and #99.57, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted references to Compensation Services Division, Adjudicator, Board officer and Medical Services Department. Updated reference to FIPP Office and Ministry of Housing and Social Development. September 3, 1996 – Policy that FIPP Office handles Canada Pension Plan requests came into effect.
APPLICATION:	Sections B, E, and F apply on or after June 1, 2009.

RE: Disclosure of Information – Other Matters **ITEM: C12-99.50**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on miscellaneous disclosure matters, including disclosure among Board departments and disclosure for research purposes.

2. The Act

Section 235(1):

> If information in a claim file, or in any other material relating to the claim of an injured or disabled worker, is disclosed for the purposes of this Act by an officer or employee of the Board to a person other than the worker, that other person must not disclose the information except as follows:
>
> (a) in compliance with an enactment of British Columbia or Canada;
>
> (b) in compliance with a subpoena, warrant or order issued or made by a court, tribunal, person or body with jurisdiction to compel the production of information;
>
> (c) for the purpose of preparing a submission or argument for a proceeding under a compensation provision, an OHS provision or Part 7 *[Appeals to Appeal Tribunal]*;
>
> (d) if the information is about a person, the person has identified the information and consented, in the manner required by the Board, to disclosure of that information.

POLICY

A. RECORDINGS OF INTERVIEWS

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

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

B. INFORMATION TO OTHER BOARD DEPARTMENTS

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

C. MEDIA ENQUIRIES OR CONTACTS

Unless designated as a media spokesperson, staff at the Board are to refer all media enquiries or contacts to the Government and Media Relations Department.

D. 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 Item C7-48.00.

E. DISCLOSURE FOR RESEARCH OR STATISTICAL PURPOSES

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

(a) the research purpose cannot reasonably be accomplished unless that information is provided in individually identifiable form or the research purpose has been approved by the Information and Privacy Commissioner.

(b) any record linkage is not harmful to the individuals that information is about and the benefits to be derived from the record linkage are clearly in the public interest.

(c) the Board has approved conditions relating to the following:

(i) security and confidentiality;

(ii) the removal or destruction of individual identifiers at the earliest reasonable times;

(iii) the prohibition of any subsequent use or disclosure of that information in individually identifiable form without the express authorization of the Board, and

(d) the person to whom that information is disclosed has signed an agreement to comply with the approved conditions, the provisions of the *Freedom of Information and Protection of Privacy Act* and any of the Board's policies and procedures relating to the confidentiality of personal information.

EFFECTIVE DATE:	Sections A, B, and C are effective June 1, 2009.
AUTHORITY:	Section 235 of the *Act*.
CROSS REFERENCES:	Item C7-48.00, *Assignments, Charges or Attachments of Compensation*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #99.40, #99.60, #99.70, #99.80, and #99.90, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted reference to officer, Claims Adjudicators, and Claims Officers. Updated reference to the Communications Department. March 3, 2003 – Inserted reference to review.
APPLICATION:	Sections A, B, and C apply on or after June 1, 2009.

RE: Reimbursement of Expenses **ITEM: C12-100.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on how the Board reimburses expenses associated with attending the Board or other places for claims related proceedings and Review Division inquiries.

2. The Act

Section 315, in part:

> The Lieutenant Governor in Council may make regulations as follows:
>
> …
>
> (b) respecting the awarding of costs by the appeal tribunal in an appeal under this Part [Part 7 – Appeals to Appeal Tribunal];
>
> (c) prescribing the circumstances under which the appeal tribunal may order the Board to reimburse the expenses incurred by a party to an appeal under this Part [Part 7 – Appeals to Appeal Tribunal];
>
> …

3. Workers Compensation Act Appeal Regulation

Section 7:

> (1) Subject to subsection (2), the appeal tribunal may order the Board to reimburse a party to an appeal under Part 7 of the Act for any of the following kinds of expenses incurred by that party:
>
> (a) the expenses associated with attending an oral hearing or otherwise participating in a proceeding, if the party is required by the appeal tribunal to travel to the hearing or other proceeding;
>
> (b) the expenses associated with obtaining or producing evidence submitted to the appeal tribunal;

(c) the expenses associated with attending an examination required under section 302(3) *[health professional assistance in specific cases]* of the Act.

(2) The appeal tribunal may not order the Board to reimburse a party's expenses arising from a person representing the party or the attendance of a representative of the party at a hearing or other proceeding related to the appeal.

POLICY

A. INTRODUCTION

Policy in this Item sets out the rules relating to the reimbursement of expenses for people attending at the Board or elsewhere in connection with claims or Review Division inquiries.

The principles relating to expenses incurred in connection with medical examinations and treatment and vocational rehabilitation programs are dealt with in Item C10-83.00 and Item C10-83.10.

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

- expenses associated with attending an oral hearing or otherwise participating in a proceeding, if the party is required by the Workers' Compensation Appeal Tribunal to travel to the hearing or other proceeding;
- expenses associated with obtaining or producing evidence submitted to the Workers' Compensation Appeal Tribunal; and
- expenses associated with attending an examination required under section 302(3) of the *Act*.

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

B. WORKERS

In addition to the specific requirements set out below, the worker must satisfy the general requirements in Item C10-83.00 and Item C10-83.10 for the payment of transportation costs and subsistence allowances.

i. Claims or Review Inquiries

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

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

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

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

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

ii. Amount of Expenses

The amount of expenses paid is calculated in accordance with the rules set out in Item C10-83.00 (transportation costs) and Item C10-83.10 (subsistence allowances for meals, accommodation, and lost time from work where the worker is not already in receipt of wage-loss benefits or vocational rehabilitation benefits from the Board).

iii. Worker Resides Outside British Columbia

The general principle stated in Item C10-83.00 is that, where the Board is paying travel costs of a worker located outside British Columbia, it will only pay the portion attributable to travel in British Columbia. This also applies to claims and review inquiries, but there are some exceptions to this principle which apply here.

If a worker resides outside British Columbia and is specifically requested by the Board to attend a claims inquiry or a review by the Review Division, the full cost of the trip will be paid by the Board.

C. EMPLOYERS

The expenses of an employer's representative may be reimbursed on the same basis as for a worker, except that compensation for lost time from work is not payable.

Not more than one employer's representative will be eligible for reimbursement for attendance at a claims inquiry or a review by the Review Division unless the second or other representative is needed as an additional witness.

D. 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 claims inquiry or review by the Review Division, it appears that it was reasonable for the worker or employer as the case may be to have assumed, prior to the claims inquiry or review by the Review Division, that the attendance of the witness would be necessary. (If a 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 Board.)

Where the expenses of a witness are payable, the amount will be the same as for a worker. A subsistence allowance for income loss under Item C10-83.10 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.

E. 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. (See Item C7-48.00.) The Board will not pay the legal costs of a worker or employer in connection with court proceedings to challenge a Board decision beyond what it may become subject to pay following the court's decision under the general law of costs.

F. EXPENSES INCURRED IN PRODUCING EVIDENCE

If a worker incurs expense in producing evidence of a kind which the Board would have sought had it not been produced by the worker, these expenses will be reimbursed by the Board as an item of administrative cost. In this connection, it makes no difference whether the expense was incurred directly or through a lawyer or other representative. However, confusion should not be made between the expenses incurred by the lawyer

or other representative on behalf of the worker and the fees of the lawyer or representative for work done. Only the former are reimbursable.

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

The Board, in a decision on a claim, refused to pay for medical reports obtained by a worker's lawyer. Although it was a normal and prudent action on the part of a responsible lawyer to seek information in order to acquaint himself properly with the client's problem before pursuing it before the Board, the information contained in the reports could have been obtained from the worker's attending physician at no cost. A simple request to the attending physician, together with a release from the worker, would have been sufficient.

It is not the Board's intention that workers or employers should incur costs in obtaining evidence, for example, accountants' fees for producing earnings information. Rather, the general approach is that the worker or employer should advise the Board of possible sources of information and the Board should carry out the necessary inquiries. This may, for example, require the Board to request that the worker provide information considered necessary to administer the claim (see Item C12-93.20).

G. DECISION ON EXPENSES

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

EFFECTIVE DATE:	Sections A, B.i, and C are effective March 3, 2003. Sections B.iii, D, F, and G are effective June 1, 2009.
AUTHORITY:	Section 315 of the *Act*. Section 7 of the *Workers Compensation Act Appeal Regulation,* B.C. Reg. 321/2002.
CROSS REFERENCES:	Item C7-48.00, *Assignments, Charges or Attachments of Compensation*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #100.00, #100.10, #100.12, #100.13, #100.14, #100.20, #100.30, #100.40, #100.50, and #100.60, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1, including renumbering from policy item #100.14 to policy item #100.13 and from policy item #100.15 to policy item #100.14.

January 1, 2015 – Consequential amendments were made arising from changes to then Chapter 10, *Medical Assistance, Rehabilitation Services & Claims Manual,* Volume II.
June 1, 2009 – Deleted reference to officer, review officer and Medical Review Panel.
March 3, 2003 – Amended regarding references to the Review Division, the Workers' Compensation Appeal Tribunal and section 7 of the *Workers Compensation Act Appeal Regulation*. Inserted references to review.

APPLICATION: Sections A, B.i, and C apply to all decisions made on or after March 3, 2003.
Sections B.iii, D, F, and G apply on or after June 1, 2009.

RE: Awarding of Costs **ITEM: C12-100.20**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on orders made under the *Act* for a party to a contested matter to pay costs to another party.

2. The Act

Section 133

(1) In an action brought under this Division [Division 3 of Part 3 – Legal Effect of Workers' Compensation System], an award for damages must include

(a) health care provided under Part 4 *[Compensation to Injured Workers and Their Dependants]*, and

(b) wages and salary paid by an employer during the period of disability

(i) that were considered by the Board in setting the amount of a periodic payment of compensation, or

(ii) that would have been considered by the Board for that purpose if the worker had elected to claim compensation.

(2) Costs may be awarded to and collected by the Board in an action taken by the Board under this Division [Division 3 of Part 3 – Legal Effect of Workers' Compensation System] even if a salaried employee of the Board acts as solicitor or counsel for the Board.

Section 315, in part:

The Lieutenant Governor in Council may make regulations as follows:

…

(b) respecting the awarding of costs by the appeal tribunal in an appeal under this Part [Part 7 – Appeals to Appeal Tribunal];

(c) prescribing the circumstances under which the appeal tribunal may order the Board to reimburse the expenses incurred by a party to an appeal under this Part [Part 7 – Appeals to Appeal Tribunal];

…

Section 343:

(1) This section applies in relation to a contested claim for compensation or any other contested matter.

(2) The Board may award to the successful party an amount the Board considers reasonable to meet the expenses to which the party has been put by reason of or incidental to contesting the matter.

(3) An order of the Board for payment by an employer or worker of an amount awarded under this section, when filed in the manner provided for the filing of certificates under section 264(2) *[collection of unpaid assessment]*, becomes a judgment of the court in which the order is filed and may be enforced accordingly.

3. Workers Compensation Act Appeal Regulation

Section 6:

The appeal tribunal may award costs related to an appeal under Part 7 of the Act to a party, payable by another party, only if the appeal tribunal determines that

(a) the other party caused costs to be incurred without reasonable cause, or caused costs to be wasted through delay, neglect or some other fault,

(b) the conduct of the other party has been vexatious, frivolous or abusive, or

(c) there are exceptional circumstances that make it unjust to deprive the successful party of costs.

POLICY

A. GENERAL

The provisions in Item C12-100.10 relate to the payment of expenses by the Board. An order for the payment of costs by one party to another under section 343 of the *Act* is a separate matter, and is an alternative that may be considered in an appropriate case.

A "contested claim", for the purposes of section 343, is one in respect of which there has been a review by the Review Division by the worker or the employer.

An award under section 343 might be made on a review but only in unusual cases. The section is limited to cases where the worker or employer abuses their respective rights under the *Act*. For instance, the worker or employer may put the opposite party to the expense of an appeal for no good reason. In other words, it may appear that a review was pursued simply because the right to request a review existed and without any substantial grounds on which the position could be argued.

An award will not likely be made under section 343 in favour of a successful appellant. Section 343(2) requires that the expenses in respect of which the award is made be "by reason of or incidental to contesting the matter." 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 "contesting" the review. If the review is not opposed by the other party, the reasons for not making an award become even stronger.

Section 6 of the *Workers Compensation Act Appeal Regulation* (B.C. Reg. 321/2002) provides that the Workers' Compensation Appeal Tribunal may award costs related to an appeal under Part 7 of the *Act* to a party if the Workers' Compensation Appeal Tribunal determines that:

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

i. Decisions on Applications for Costs

Only in rare cases will a review by the Review Division be sufficiently without merit to justify an award under section 343.

B. APPLICATION FOR COSTS BY DEPENDANT

On an application under the predecessor to section 311 of the *Act*, the Board certified that the defendant to a third party action was not an employer under the *Act*. The plaintiff then applied for an order for costs of the proceedings before the Board to be paid by the third party defendant. The Board determined that:

". . . the authority of the Board to enforce payment of an order for costs is limited to an order for payment by an employer, or by a worker. The Third Party in this case is neither an employer nor a worker under [then] Part 1, 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 [now section 343] has a historical explanation that does not reflect any rational policy currently relevant. But it is a clear limitation in the *Act*, and it must therefore be followed."

The question arises whether an award under section 343 can be made in favour of the dependants of a deceased worker. Such an award would not contradict the previous determination, as the person against whom it would be made is an employer under the *Act*. However, it was considered unfair to make such an award if the employer could not get a like award against the dependant. Therefore, an award of costs will not be made in favour of a dependant of a deceased worker against an employer.

C. 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 in Sections A through F of Item C12-100.10. 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.

D. REVIEW OR APPEAL DECISION DIRECTING REASSESSMENT OR REDETERMINATION

It may happen that, instead of reaching a specific finding on a matter, the Review Division or the Workers' Compensation Appeal Tribunal will direct that the Board reassess or redetermine something, for example, permanent partial disability benefits. The Review Division or the Workers' Compensation Appeal Tribunal finding is properly implemented if the reassessment or redetermination is carried out even if the conclusion reached is the same as the one that was previously reviewed by the Review Division or appealed to the Workers' Compensation Appeal Tribunal. However, if the Board officer implementing the Review Division or the Workers' Compensation Appeal Tribunal finding is the same one who made the original decision against which the review or appeal was made, and if that person's decision is still negative, the matter is to be referred to a different Board officer for a second look. If a difference of opinion results from the second look, the decision of the second Board officer will prevail.

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

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

EFFECTIVE DATE:	Sections A (except A.i) and D are effective June 1, 2009. Sections A.i and B are effective March 3, 2003.
AUTHORITY:	Sections 133, 315, and 343 of the *Act*. Section 6 of the *Workers Compensation Act Appeal Regulation,* B.C. Reg. 321/2002.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #100.70, #100.73, #100.71, #100.72, and #100.75, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted references to Medical Review Panel and Compensation Services Division. March 3, 2003 – Inserted references to review and section 6 of the *Workers Compensation Act Appeal Regulation*. Amended regarding reference to section 11 of the *Workers Compensation Act*, R.S.B.C. 1996, c. 492. Amended reference to Review Division. Former policy item #100.75 was moved from Chapter 13 and amended to include references to the Review Division or the Workers' Compensation Appeal Tribunal.
APPLICATION:	Sections A (except A.i) and D apply on or after June 1, 2009. Sections A.i and B apply to all decisions made on or after March 3, 2003.

RE: Payment of Claims Pending Appeals **ITEM: C12-100.30**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on when and how claim payments are made pending requests for review at the Review Division and appeals to the Workers' Compensation Appeal Tribunal.

2. The Act

Section 125:

(1) The Board may at any time, on its own initiative or on application, reopen a matter that had been previously decided under a compensation provision by the Board or an officer or employee of the Board if, since the decision was made in the matter,

(a) there has been a recurrence of a worker's injury, or

(b) there has been a significant change in a worker's medical condition that the Board had previously decided was compensable.

(2) If the Board determines that the circumstances described in subsection (1) justify a change in a previous decision respecting compensation or rehabilitation, the Board may make a new decision that varies the previous decision or order.

Section 270, in part:

(1) A request for a review must be filed as follows:

(a) if a shorter time period is not prescribed under paragraph (b), within 90 days after the Board's decision or order is made;

(b) if a time period shorter than 90 days is prescribed by regulation of the Lieutenant Governor in Council with respect to the type of decision or order to be reviewed, within the shorter time period.

(2) The chief review officer may extend the time to file a request for a review, including making an extension after the time to file has expired, if this is done on application and the chief review officer is satisfied that

(a) special circumstances existed that preclude or precluded the filing of a request for a review within the applicable time period required by subsection (1), and

(b) an injustice would otherwise result.

…

Section 275:

(1) If, following a review under this Part [Part 6 – Review of Board Decisions], a review officer's decision requires payments to be made to a worker or a deceased worker's dependants, the Board must

(a) begin any periodic payments, and

(b) pay any lump sum due under section 167 *[payment to dependent spouse or foster parent]*.

(2) In the absence of fraud or misrepresentation, an amount paid under subsection (1) to a worker or a deceased worker's dependants is not recoverable.

(3) If a review officer has made a decision described under subsection (1), the Board must defer the payment of any compensation applicable to the time period before that decision

(a) for a period of 40 days following the review officer's decision, and

(b) if the review officer's decision is appealed under section 288 *[appeal of review decisions]*, for a further period until the appeal tribunal has made a final decision or the appeal has been withdrawn, as the case may be.

(4) Subsection (3) applies despite the following:

(a) section 168(2) *[dependants of deceased worker]*;

(b) section 191(1) *[temporary total disability]*;

(c) section 192(1) *[temporary partial disability]*;

(d) section 194(1) *[permanent total disability]*;

(e) section 195(1) *[permanent partial disability: general rules]*;

(f) section 196(3) *[permanent partial disability: exception to general rules]*.

Section 289:

(1) The following may be appealed to the appeal tribunal:

(a) a determination or order under section 50 *[response to worker complaint respecting prohibited action]*;

(b) a refusal to make an order under that section;

(c) a cancellation of an order under that section.

(2) A decision to reopen or not to reopen a matter on an application under section 125 *[recurrence of injury or significant change in medical condition]* may be appealed to the appeal tribunal.

Section 312:

(1) If the appeal tribunal's decision on an appeal requires the payment of compensation, all or part of which was deferred under section 275(3) *[payment following review decision]*, interest must be paid on the deferred amount of that compensation as specified in subsection (2).

(2) Interest payable under subsection (1) must be calculated in accordance with the policies of the board of directors and begins

(a) 41 days after the review officer made the appealed decision, or

(b) on an earlier day determined in accordance with the policies of the board of directors.

POLICY

A. REQUESTS FOR REVIEW AT REVIEW DIVISION – NEW CLAIMS

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

When a decision is made to allow a claim that has been protested by an employer, the employer will be advised of the decision and reasons, where possible by telephone, and given an opportunity to provide any additional information. This is similar to the requirement in policy in Item C12-99.10 that a worker be advised if the indication on a

claim is that it may be disallowed. If the decision remains that the claim should be allowed, payments will be commenced immediately and a letter explaining the decision and reasons will be sent to the employer. The letter will advise the employer of their right to request a review by the Review Division.

Section 270 of the *Act* provides that an employer can request a review up to 90 days from the decision allowing a claim.

If the Review Division reverses the decision to allow the claim, payments are immediately terminated but no attempt is made to recover payment incorrectly made to the worker, unless there was evidence of fraud or misrepresentation. The employer's sector or rate group will be relieved of the claim costs pursuant to policy in Item C17-114.10.

B. APPEALS TO WORKERS' COMPENSATION APPEAL TRIBUNAL – REOPENING OF MATTERS PREVIOUSLY DECIDED

If a decision is made to reopen a matter under section 125 of the *Act*, the employer is advised in writing. If the employer objects to this decision, the employer will be advised of the right to appeal directly to the Workers' Compensation Appeal Tribunal under section 289.

If the Workers' Compensation Appeal Tribunal reverses the decision to reopen the matter, payments are immediately terminated. No attempt is made to recover payments incorrectly made to the worker unless there was evidence of fraud or misrepresentation. The employer's sector or rate group will be relieved of the claim costs pursuant to policy in Item C17-114.10.

C. IMPLEMENTATION OF REVIEW DIVISION DECISIONS

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

1. Any benefits payable from the date of the Review Division decision forward will be paid without delay.

2. Any benefits payable for the period of time prior to the date of the Review Division decision (retroactive benefits) will be paid after 40 days have elapsed following the date of the Review Division decision, unless an appeal has been filed with the Workers' Compensation Appeal Tribunal.

3. If there is an appeal of the decision under section 288 of the *Act*, retroactive benefits will not be paid until the Workers' Compensation Appeal Tribunal has made a final decision or the appeal has been withdrawn.

4. The decision of the Workers' Compensation Appeal Tribunal will be implemented upon its receipt by the Board. The worker's entitlement to retroactive benefits which were deferred according to #3 above will then be determined in accordance with the decision of the Workers' Compensation Appeal Tribunal.

5. Where retroactive benefits are payable, after the decision of the Workers' Compensation Appeal Tribunal, interest is to be paid in accordance with the Board's general policy on the payment of interest on retroactive benefits as set out in policy in Item C7-50.00. Where interest is payable under section 312(1), interest will be paid beginning 41 days after the date on which the Review Division made its decision. The amount of interest to be paid is to be calculated in accordance with the interest rates set out in policy in Item C7-50.00.

EFFECTIVE DATE:	Sections A and B are effective June 1, 2009. Section C is effective January 1, 2014.
AUTHORITY:	Sections 125, 270, 275, 289, and 312 of the *Act*.
CROSS REFERENCES:	Item C7-48.10, *Overpayments/Money Owed to the Board*; Item C7-50.00, *Interest*; Item C17-114.10, *Investigation Costs*, of *the Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #100.80, #100.81, #100.82, and #100.83, consequential to reformatting and renumbering policies in Chapter 12, *Claims Procedures*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. January 1, 2015 – Housekeeping change to make consequential amendment to point #5 of policy, resulting from changes to former policy item #50.00, *Interest,* of the *Rehabilitation Services & Claims Manual* Volume II made effective January 1, 2014. June 1, 2009 – Deleted reference to Claims Department and officer. March 3, 2003 – Replaced former policy item #105.20, which was deleted from Chapter 13 and amended to include references to the Workers' Compensation Appeal Tribunal. Replaced former policy item #105.10, which was deleted from Chapter 13 and amended to include references to the Review Division. Former policy item #100.83 was moved from Chapter 13 and amended to include references to then section 258 of the *Act*, the Review Division and the Workers' Compensation Appeal Tribunal and to delete a reference to former policy item #45.61.
APPLICATION:	Sections A and B apply on or after June 1, 2009. Section C applies to all decisions made on or after January 1, 2014.

RE:	Reviews and Appeals – General	ITEM:	C13-100.00

BACKGROUND

1. Explanatory Notes

The *Workers Compensation Amendment Act (No. 2), 2002* ("*Amendment Act (No. 2), 2002*") made significant changes to the workers' compensation appeal system.

Prior to the *Amendment Act (No. 2), 2002* being brought into force, there were three avenues of appeal with respect to compensation and rehabilitation matters:

- initial decisions were appealable to the Workers' Compensation Review Board;
- Review Board findings were appealable to the Board's Appeal Division; and
- initial decisions, Review Board findings and Appeal Division decisions were all appealable on medical issues to Medical Review Panels. Medical Review Panel decisions on medical issues were binding upon all levels of decision-making in the system.

Provisions of the *Amendment Act (No. 2), 2002* closing access to Medical Review Panels were brought into force effective November 30, 2002. The Medical Review Panels continued to address appeals submitted prior to that time or in accordance with the transitional provisions of the *Amendment Act (No. 2), 2002*. Once those appeals were dealt with, the Medical Review Panels ceased to exist.

Other provisions of the *Amendment Act (No. 2), 2002* were brought into force effective March 3, 2003. Except for purposes of addressing certain matters covered by the transitional provisions of the *Amendment Act (No. 2), 2002*, the Workers' Compensation Review Board and the Board's Appeal Division ceased to exist as of that date.

Effective March 3, 2003, the following avenues of review and appeal existed with respect to compensation and rehabilitation matters:

- initial decisions (except decisions on whether to reopen a previous matter) were reviewable by a review officer, who is an officer of the Board;
- most, but not all, review officer decisions were appealable to the independent Workers' Compensation Appeal Tribunal ("WCAT"); and

- initial decisions on whether to reopen a previous matter were directly appealable to WCAT.

Effective August 14, 2020, initial decisions on whether to reopen a previous matter are reviewable by a review officer.

The Board has established the Review Division comprised of review officers to deal with reviews. For the most part, there will be no policies in relation to the operations of the Review Division. Readers should consult the *Act*, the Review Division and the practices and procedures issued by the Review Division to determine their rights and responsibilities in relation to this review function.

WCAT is independent of the Board. Readers should consult the *Act* and contact WCAT to determine their rights and responsibilities in relation to this appeal function.

2. The Act

The provisions of the *Act* are too extensive to quote in this Chapter. Readers are referred to Part 6 [*Review of Board Decisions*] and Part 7 [*Appeals to Appeal Tribunal*] of the *Workers Compensation Act* on the following website:

http://www.bclaws.ca/civix/document/id/complete/statreg/19001_00

POLICY

There is no POLICY for this Item.

EFFECTIVE DATE:	June 1, 2009
AUTHORITY:	*Workers Compensation Amendment Act (No. 2), 2002.*
CROSS REFERENCES:	Item C13-101.00, *Reviews and Appeals – Review Division - Practices and Procedures*; Item C13-102.00, *Reviews and Appeals – Workers' Compensation Appeal Tribunal*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	June 2023 − Housekeeping amendment. April 3, 2023 − Housekeeping changes made to the Explanatory Notes portion of the Background section to reflect amendments to the *Act* by the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41). December 1, 2022 − Housekeeping changes made to the Explanatory Notes portion of the Background section to reflect amendments to the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23). April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted references to the Medical Review Panel, Review Board and the Appeal Division. March 3, 2003 − New Item resulting from the *Workers Compensation Amendment Act (No. 2), 2002.*
APPLICATION:	Applies on or after June 1, 2009.

RE:	Reviews and Appeals – Review Division – Practices and Procedures	ITEM:	C13-101.00

BACKGROUND

1. Explanatory Notes

The Board may establish practices and procedures for the conduct of reviews. Those practices and procedures are established under the direction of the President of the Board or the President's delegate.

2. The Act

Section 272(2):

> Subject to any Board practices and procedures for the conduct of a review, a review officer may conduct a review as the officer considers appropriate to the nature and circumstances of the decision or order being reviewed.

Section 338(8):

> The Board may establish practices and procedures for carrying out its responsibilities under this Act, including specifying time periods within which certain steps must be taken and the consequences for failing to comply within those time periods.

POLICY

As with other practices or procedures established by the Board, the practices and procedures for the conduct of reviews by the Review Division will be established by the President or under the direction of the President or delegate.

EFFECTIVE DATE:	March 3, 2003
AUTHORITY:	Sections 272(2) and 338 of the *Act.*
CROSS REFERENCES:	Item C13-100.00, *Reviews and Appeals – General*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. March 3, 2003 − New Item resulting from the *Workers Compensation Act (No. 2), 2002*.
APPLICATION:	

RE: Reviews and Appeals – Workers' Compensation Appeal Tribunal **ITEM: C13-102.00**

BACKGROUND

1. Explanatory Notes

Effective March 3, 2003, the *Workers Compensation Amendment Act (No. 2), 2002*, established the Workers' Compensation Appeal Tribunal ("WCAT") as the final level of appeal on most matters in the workers' compensation system. WCAT is external to, and independent from, the Workers' Compensation Board. Its chair is appointed by the Lieutenant Governor in Council. Its vice-chairs and members are appointed by the chair, after consultation with the Minister.

Section 289 of the *Act* directs that two categories of Board decisions are directly appealable to WCAT:

- A decision to reopen or not to reopen a matter on an application under section 125 [*recurrence of injury or significant change in medical condition*];
- A determination, an order, a refusal to make an order or a cancellation of an order made by the Board under section 50 [*reponse to worker complaint respecting prohibited action*].

Section 288 of the *Act* explains that with certain exceptions, a final decision made by a review officer in a review under Part 6 of the *Act* [*Review of Board Decisions*] may be appealed to WCAT.

Those exceptions are:

- a decision respecting an order under Part 2 *[Occupational Health and Safety]*, other than any of the following orders:
    - an order relied on to impose an administrative penalty under section 95(1) *[administrative penalties – higher maximum amount]*;
    - an order imposing an administrative penalty under section 95(1);
    - an order under section 96 [*certificates issued under OHS provisions*] to cancel or suspend a certificate;
- a decision respecting matters referred to in section 155 *[vocational rehabilitation]* of the *Act*;

- a decision respecting the application under section 195(1) [*compensation for permanent partial disability*] of the *Act* of rating schedules compiled under subsection (3) of that section if the specified percentage of impairment has no range or has a range that is not greater than 5%;

- a decision respecting commutations under section 230 [*commutation of lump sum payments*];and

- a decision in a class of decisions prescribed by the Lieutenant Governor in Council respecting the conduct of a review.

In the *Workers Compensation Act Appeal Regulation* (B.C. Reg. 321/2002), the Lieutenant Governor in Council prescribed the following decisions respecting the conduct of a review as not being appealable to WCAT:

- decisions applying time periods specified by the Board under section 338 [*Board practices and procedures*] of the *Act* (time periods specified in the Board's practices and procedures for taking certain steps);

- decisions made under the following provisions of the *Act*

  - section 270(2) (extensions of time to request a review);

  - section 271(2) (deeming an employers' adviser or an organized group of employers to be the employer);

  - section 272(2) (subject to any Board practices and procedures, conducting a review as the review officer considers appropriate);

  - section 272(3) (completing a review or determining a review has been abandoned if a party does not make a submission within the time required by the Board's practices and procedures);

  - section 272(4) (requiring the employer to post a notice in the workplace of reviews relating to certain occupational health and safety matters);

  - section 272(5) (suspending a review to allow a review officer to deal with related matters at the same time); and

  - section 272(8) (extending the time for a review officer to make a decision);

- an order by the chief review officer under section 270(3) that the request for review operates as a stay of proceedings or suspends operation of the decision under review;

- decisions about whether or not to refer a decision back to the Board under section 272(9)(b) of the *Act*; and

- decisions respecting the conduct of a review if the review is in respect of any matter that is not appealable to WCAT under section 288(2)(b) to (e) of the *Act*.

2. The Act

The provisions of the *Act* are too extensive to quote in this Chapter. Readers are referred to Part 6 [*Review of Board Decisions*] and Part 7 [*Appeals to Appeal Tribunal*] of the *Workers Compensation Act* on the following website:

http://www.bclaws.ca/civix/document/id/complete/statreg/19001_00

POLICY

There is no POLICY for this Item.

EFFECTIVE DATE:	March 3, 2003
AUTHORITY:	Sections 277 to 314, *Workers Compensation Act*; s. 4, *Workers Compensation Act Appeal Regulation* (B.C. Reg. 321/2002)
CROSS REFERENCES:	Item C13-100, *Reviews and Appeals – General*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	June 2023 − Housekeeping amendment. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. March 3, 2003 − New Item resulting from the *Workers Compensation Amendment Act (No. 2), 2002*.

RE:	Changing Previous Decisions – General	ITEM:	C14-101.01

BACKGROUND

1. Explanatory Notes

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

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

More information about these mechanisms is presented in the Items C14-102.01 to C14-104.01.

2. The Act

See Items C14-102.01 to C14-104.01.

POLICY

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

(a) New matters not previously decided

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

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

- Initial entitlement to temporary or permanent disability benefits;

- Acceptability of additional medical conditions identified during the adjudication of a claim or acceptability of further injury or disease that arises as a consequence of a work injury;

- Sections of the *Act* which give the Board broad discretion to make decisions regarding entitlement at various times over the course of a claim. In applying these provisions, the Board may consider a new matter that arises as a result of new information or a change in circumstances that occurs after a previous decision. Two examples are health care benefits and vocational rehabilitation services.

- Health care benefit entitlement – Sections 156, 157, and 158 of the *Act* enable the Board to approve health care treatment and services to aid in a worker's recovery from the compensable injury or occupational disease. Consideration for health care benefits may occur at various points during the claim as the nature and severity of the worker's compensable injury or occupational disease changes and/or there is a determination that additional treatments or services will assist in the worker's recovery.

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

- Vocational rehabilitation entitlement – Consideration of entitlement to vocational rehabilitation services under section 155 may be required at various points during the claim to assist in a worker's recovery and return to work.

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

- A new matter may arise as a result of legislative provisions that expressly direct the Board to make certain decisions or take certain actions at specified points in the claim. If the Board fails to render these decisions or take these actions at the specified point, the Board must make the decision as soon as the error is discovered in order to fulfill the requirements of the *Act*. These decisions would have prospective application. For example, under section 211 of the *Act*, if a worker's temporary disability continues for ten cumulative weeks for which wage-loss benefits are payable, the Board must determine the amount of average earnings of the worker based on the worker's gross earnings for the 12-month period immediately preceding the date of the injury.

(b) Implementation of Review Division Decisions or WCAT Decisions

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

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

The reconsideration and reopening requirements under sections 123 and 125 do not limit changes to previous decisions that are required in order to fully implement decisions of the Review Division or the WCAT.

EFFECTIVE DATE:	June 1, 2009
AUTHORITY:	Sections 1, 123, 124, 125, 272(10), and 309 of the *Act*.
CROSS REFERENCES:	Item C11-88.00, *Vocational Rehabilitation – Nature and Extent of Programs and Services*; Item C14-102.01, *Changing Previous Decisions – Reopenings*; Item C14-103.01, *Changing Previous Decisions – Reconsiderations*; Item C14-104.01, *Changing Previous Decisions – Fraud and Misrepresentation*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	October 29, 2020 – Housekeeping change made to correct grammatical error. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted reference to officer and replace WCB with Board. January 1, 2005 – Amended to clarify the difference between a new decision and a change in a previous decision, and to provide guidance on the implementation of Review Division and WCAT decisions. Applies to all decisions on or after January 1, 2005. March 3, 2003 − New Item consequential to the *Workers Compensation Amendment Act (No. 2), 2002.*
APPLICATION:	Applies on or after June 1, 2009.

RE: Changing Previous Decisions – Reopenings **ITEM: C14-102.01**

BACKGROUND

1. Explanatory Notes

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

2. The Act

Section 125:

(1) The Board may at any time, on its own initiative or on application, reopen a matter that had been previously decided under a compensation provision by the Board or an officer or employee of the Board if, since the decision was made in the matter,

(a) there has been a recurrence of a worker's injury; or

(b) there has been a significant change in a worker's medical condition that the Board had previously decided was compensable.

(2) If the Board determines that the circumstances described in subsection (1) justify a change in a previous decision respecting compensation or rehabilitation, the Board may make a new decision that varies the previous decision or order.

POLICY

(a) General

The reopening of a previous decision does not affect the application of the decision to the period prior to the significant change in the worker's medical condition or the recurrence of the worker's injury. Rather, it enables the Board to reopen matters previously decided and determine a worker's ongoing entitlement. A reopening involves the adjudication of new matters.

(b) A reopening is not a reconsideration

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

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

(c) Grounds for reopening

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

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

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

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

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

(d) Recurrence of injury

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

- an additional period of wage-loss benefits where no permanent disability benefits were previously provided in respect of the compensable injury; and
- an additional period of wage-loss benefits where permanent disability benefits were previously provided in respect of the compensable injury.

An example of a recurrence of an injury is where a worker has a compensable injury for which wage-loss benefits are paid. The injury resolves and the claim is closed, but later becomes disabling again without any intervening new injury. In these situations it is considered that the original injury has recurred. The result is that the worker may be

entitled to an additional period of wage-loss benefits and/or consideration for permanent disability benefits under the original claim.

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

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

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

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

(e) Reopening on application or on own initiative

Section 125(1) sets out the two ways in which the Board may reopen a matter that has been previously decided by the Board: on its own initiative, or on application.

A request for a reopening of a previous decision will be considered on application where the worker refers specifically to section 125(1) of the *Act* or uses language substantially similar to that section. An application may be submitted to the Board in written or verbal form.

A reopening request will not be considered on application where:

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

EFFECTIVE DATE:	October 21, 2020
AUTHORITY:	Section 125 of the *Act.*
CROSS REFERENCES:	Item C14-101.01, *Changing Previous Decisions – General*; Item C14-103.01, *Changing Previous Decisions – Reconsiderations*; Item C14-104.01, *Changing Previous Decisions – Fraud and Misrepresentation*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	October 21, 2020 – Amended to reflect amendment to review provision in the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. August 1, 2006 − Consequential amendment was made to section (d) of policy resulting from changes to former policy item #1.03, *Scope of Volumes I and II in Relation to Benefits for Injured Workers,* of the *Rehabilitation Services & Claims Manual* Volume II. April 8, 2005 − Housekeeping amendment was made to correct numbering. January 1, 2005 − Amended to clarify recurrence of injury and to distinguish between a reopening on application and a reopening on own initiative. March 18, 2003 − Amended to clarify that a reopening allows compensation or rehabilitation benefits to be “varied” and that disputes over a decision to reopen or not to reopen a matter “on application” are appealable directly to WCAT under section 240(2). March 3, 2003 − New Item consequential to the *Workers Compensation Amendment Act (No. 2), 2002*.
APPLICATION:	Applies to all decisions made on or after October 21, 2020.

RE:	Changing Previous Decisions – Reconsiderations	ITEM:	C14-103.01

BACKGROUND

1. Explanatory Notes

The *Act* provides the Board may reconsider previous decisions. Subject to certain restrictions, the Board may reconsider a decision made under the compensation provisions of the *Act* during the period of 75 days subsequent to the decision being made; after 75 days, the Board may only reconsider a decision that contains an obvious error or omission.

2. The Act

Section 1, in part:

> **"reconsider"** means to make a new decision in a matter previously decided such that the new decision confirms, varies or cancels the previous decision or order;
>
> ...

Section 123:

> (1) Subject to subsection (2), the Board may, on its own initiative, reconsider a decision or order made under a compensation provision by the Board or an officer or employee of the Board.
>
> (2) Subject to subsection (3), the Board may not reconsider a decision or order referred to in subsection (1) if any of the following apply:
>
> (a) more than 75 days have elapsed since the decision or order was made;
>
> (b) a request for review has been filed under section 270 *[making request for a review]* in respect of the decision or order;
>
> (c) a notice of appeal has been filed under section 292 *[how to appeal]* in respect of the decision or order.

(3) The Board may, on its own initiative, reconsider a decision or order after the 75 days referred to in subsection (2)(a) have elapsed, if the decision or order contains an obvious error or omission.

POLICY

(a) Definition of reconsideration

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

(b) The purpose of section 123

The Board's authority to reconsider previous decisions is found in section 123 of the *Act*. The purpose of this section is to promote finality and certainty within the workers' compensation system, while still allowing the Board to remedy obvious errors and omissions.

Part 6 of the *Act − Review of Board Decisions* – establishes a right to request a review by a review officer where a party disagrees with a decision made at the initial decision-making level. It is this review, rather than the application of the Board's reconsideration authority, which is intended to be the dispute resolution mechanism for initial decisions of the Board.

It is significant that sections 123(1) and (3) only authorize the Board to reconsider a decision "on its own initiative". This is to be contrasted with the Board's authority to reopen a matter "on its own initiative, or on application" under section 125(1). It is also to be contrasted with section 273 and section 310, which authorize a review officer and the appeal tribunal, respectively, to reconsider decisions on application in certain circumstances.

The use of the words "on its own initiative" in sections 123(1) and (3), with no provision for "on application", and the availability of a review mechanism in Part 6 of the *Act*, indicate that the Board is not intended to set up a formal application for reconsideration process to resolve disputes that parties may have with decisions.

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

(c) Advice to parties

Parties to a decision will be advised at the time the decision is made, of the right to request a review of the decision under section 268. A party who approaches the Board to have the decision reconsidered will be reminded of the party's right to request a review under section 268. If the Board reconsiders a decision before the request for review is made, the Board will advise the parties to the decision of the reconsidered decision. The reconsidered decision, to confirm, vary or cancel the previous decision, gives rise to a new right to request a review under section 268.

(d) Restrictions on reconsiderations

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

(i) Reconsiderations within 75 days under section 123(1) of the *Act*

- The Board may not reconsider a decision under section 123(1) more than 75 days after the decision was made. The 75 day period commences on the date the decision was made.

- The Board may not reconsider a decision if a request for a review has been filed with the Review Division under section 270 in respect of a decision described in section 268. The filing of a request for review under section 270 immediately terminates the authority of the Board to reconsider a previous decision, even if 75 days has not passed since the decision was made.

- The Board may not reconsider a decision if an appeal has been filed with the Workers' Compensation Appeal Tribunal ("WCAT") under section 292 in respect of a decision described in section 289. The filing of an appeal under section 292 immediately terminates the authority of the Board to reconsider the decision, even if 75 days has not passed since the decision was made.

(ii) Reconsiderations after 75 days under section 123(3) of the *Act*

- The Board may not reconsider a decision if a request for a review has been filed with the Review Division under section 270 in respect of a decision described in section 268. The filing of a request for review under section 270 immediately terminates the authority of the Board to reconsider a previous decision.

- The Board may not reconsider a decision if an appeal has been filed with WCAT under section 292 in respect of a decision described in section 289.

The filing of an appeal under section 292 immediately terminates the authority of the Board to reconsider the decision.

(iii) Implicit restrictions on reconsideration under sections 123(1) and (3)

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

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

Section 310 of the *Act* provides for WCAT to reconsider its own decisions and decisions of the former Appeal Division under certain limited conditions. The Legislature therefore "turned its mind" to the extent that former appellate decisions should be reconsidered and legislated its intent.

(e) Grounds for reconsiderations

(i) Reconsiderations within 75 days under section 123(1) of the *Act*

Subject to the restrictions set out above, the Board may reconsider a decision on its own initiative under section 123(1) where the Board is satisfied reconsideration is appropriate based on applicable law and policy, and the merits and justice of the case. In reconsidering a decision under section 123(1), the Board may reweigh the evidence and substitute its judgment for that of the initial decision-maker.

Examples of circumstances that may warrant reconsideration include, but are not limited to, the following:

- there is new evidence indicating that a prior decision was made in error;
- there has been a mistake of evidence, such as:
  - material evidence was initially overlooked, or
  - facts were mistakenly taken as established which were not supported by any evidence or by any reasonable inference from the evidence;
- there has been a policy error such as:
  - applying an applicable policy incorrectly, or
  - not applying an applicable policy; or

- there has been an error of law, such as a failure by the Board to follow the express terms of the *Act*.

(ii) Reconsiderations after 75 days under section 123(3) of the *Act*

Subject to the restrictions set out above, and after the 75-day period has elapsed since the decision was made, the Board may reconsider a decision on its own initiative under section 123(3) only where the decision contains an obvious error or obvious omission.

An "error" is a mistake or something that is wrong or incorrect; an "omission" is the failure to do something that is required by law or policy.

An obvious error or omission is easily and plainly identifiable with minimal investigation. An obvious error or omission does not arise where one simply disagrees with the decision-maker's exercise of judgment or weighing of the evidence.

The Board may reconsider a decision under section 123(3) only where there has been an obvious error or omission in the application of law and/or policy; or an obvious error or omission in relation to a mistake of evidence. New evidence may be considered under section 123(3) only where it plainly identifies an obvious error or omission and is material and substantial to the decision. If the new evidence is submitted by a party, the Board considers whether the new evidence was submitted without unreasonable delay.

Section 123(3) applies to obvious errors and omissions in a decision made by the Board other than review officer decisions.

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

(i) Reconsiderations within 75 days under section 123(1) of the *Act*

A Board officer, Manager or Director may only reconsider a decision where appropriate based on the applicable law and policy, and the merits and justice of the case. A Board officer, Manager or Director may reweigh the evidence and substitute their own judgment for that of the initial decision-maker.

(ii) Reconsiderations after 75 days under section 123(3) of the *Act*

A Board officer, Manager or Director may only reconsider a decision where there is an obvious error or obvious omission.

Prior approval of a Manager or Director is required before a Board officer proceeds with a reconsideration under section 123(3).

(g) Correction of administrative errors

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

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

An administrative error may occur when the decision as recorded does not clearly reflect the intention of the Board. For example, a decision letter states "I do accept the degenerative changes as part of the claim", however; the remainder of the letter and the evidence on the claim clearly illustrate that the Board intended that the letter state "I do not accept".

This process for correcting administrative errors, however, cannot be applied to change decisions.

EFFECTIVE DATE:	October 29, 2020
AUTHORITY:	Section 123 of the *Act*.
CROSS REFERENCES:	Item C14-101.01, *Changing Previous Decisions – General*; Item C14-102.01, *Changing Previous Decisions – Reopenings*; Item C14-104.01, *Changing Previous Decisions – Fraud and Misrepresentation*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	June 1, 2024 − Housekeeping changes made to modernize terminology by removing gendered language. October 29, 2020 – Amended to reflect amendments to reconsideration provision in the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. April 1, 2010 – Deleted reference to providing written communication of rights of review. June 1, 2009 – Deleted references to Board officers and decision-maker. April 8, 2005 − Housekeeping amendment to correct numbering. January 1, 2005 – Amendments to include policy on the correction of administrative errors. Applied to all decisions on or after January 1, 2005.

March 3, 2003 – New Item consequential to the *Workers Compensation Amendment Act (No. 2), 2002.*

APPLICATION: Applies to all decisions made on or after October 29, 2020.

RE: Changing Previous Decisions – Fraud and Misrepresentation **ITEM: C14-104.01**

BACKGROUND

1. Explanatory Notes

Section 124 allows the Board to set aside any decision or order under the compensation provisions of the *Act* that has resulted from fraud or misrepresentation.

2. The Act

Section 124:

> The Board may at any time set aside a decision or order made under a compensation provision by an officer or employee of the Board if that decision or order resulted from fraud or misrepresentation of the facts or circumstances on which the decision or order was based.

POLICY

In order for a decision or order to be set aside as a result of misrepresentation, there must be more than innocent misrepresentation.

The misrepresentation must have been made, or acquiesced in, by the worker, dependant, employer or other person with evidence to provide, knowing it to be wrong or with reckless disregard as to its accuracy, and the decision or order must have been made in reliance on the misrepresentation. Misrepresentation would include concealing information, as well as making a false statement.

EFFECTIVE DATE:	March 3, 2003
AUTHORITY:	Section 124 of the *Act*.
CROSS REFERENCES:	Item C14-101.01, *Changing Previous Decisions – General*; Item C14-102.01, *Changing Previous Decisions – Reopenings*; Item C14-103.01, *Changing Previous Decisions – Reconsiderations*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. March 3, 2003 − New Item consequential to the *Workers Compensation Amendment Act (No. 2), 2002.*
APPLICATION:	Applies to all decisions on and after March 3, 2003.

RE: Advice and Assistance **ITEM: C15-109.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on advice and assistance for workers and employers regarding compensation claims.

2. The Act

Section 350:

(1) Workers' advisers, employers' advisers and other employees necessary to enable the workers' advisers and employers' advisers to perform their duties under this Division [Division 6 of Part 8 – Workers' Advisers, Employers' Advisers and Other Assistance] may be appointed under the *Public Service Act* as employees of the minister's ministry.

(2) The following apply to a ministry employee appointed under subsection (1) as a workers' adviser or employers' adviser:

(a) the employee need not be a member of the Law Society of British Columbia;

(b) section 15 *[restrictions on practice of law]* of the *Legal Profession Act* does not apply to the employee if that employee is not a member of the Law Society of British Columbia.

(3) The minister may request that the Board reimburse the government for all amounts paid by the government for the reasonable expenses properly incurred by the government in administering workers' and employers' advisers programs.

(4) On receiving a request under subsection (3), the Board must pay the amount requested to the Minister of Finance.

Section 351:

A workers' adviser must

(a) give assistance to a worker or dependant having a claim under this Act, unless the workers' adviser considers the claim has no merit,

(b) on claims matters, communicate with or appear before the Board and the appeal tribunal on behalf of a worker or dependant if the adviser considers assistance is required, and

(c) advise workers and dependants regarding the interpretation and administration of this Act or any regulations or decisions made under this Act.

Section 352:

An employers' adviser must

(a) give assistance to an employer respecting any claim under this Act of

(i) a worker of the employer, or

(ii) a dependant of such a worker

unless the employer's adviser considers the claim has no merit,

(b) on claims matters, communicate with or appear before the Board and the appeal tribunal on behalf of an employer if the adviser considers assistance is required, and

(c) advise employers regarding the interpretation and administration of this Act or any regulations or decisions made under this Act.

Section 353:

(1) The workers' advisers, the employers' advisers and the staff of those advisers must have access at any reasonable time to the complete claims files of the Board and any other material relating to the claim of an injured or disabled worker.

(2) The advisers and staff referred to in subsection (1) must treat the information contained in the claims files as confidential to the same extent as the information is treated by the Board.

(3) An employers' adviser must not report or disclose to an employer information obtained from or at the Board of a type that would not be disclosed to the employer by the Board.

Section 354:

(1) A person may

(a) give advice respecting the interpretation or administration of this Act, the policies of the board of directors, the Board's practices and procedures or any regulations, orders or decisions under this Act, or

(b) act on behalf of a person by

(i) communicating with the Board, an officer or employee of the Board, the appeal tribunal or any other person acting under this Act, or

(ii) appearing before the Board, an officer or employee of the Board or the appeal tribunal.

(2) Section 15 *[restrictions on practice of law]* of the *Legal Profession Act* does not apply to a person while the person performs functions referred to in subsection (1).

POLICY

A. INTRODUCTION

Workers or employers requiring advice or assistance on some aspect of a compensation claim are advised in the first instance to contact the Board. For difficulties that are not resolved by this procedure, the *Act* has established Workers' Advisers and Employers' Advisers.

A worker or employer may also obtain advice and assistance from other sources, for example, trade unions, and employers' associations.

B. WORKERS' ADVISERS

The duties of a Workers' Adviser are to:

1. give assistance to a worker or dependant having a claim under the *Act*, unless the Workers' Adviser considers the claim has no merit;

2. on claims matters, communicate with or appear before the Board and the Workers' Compensation Appeal Tribunal on behalf of a worker or dependant if the Adviser considers assistance is required; and

3. advise workers and dependants regarding the interpretation and administration of the *Act* or any regulations or decisions made under it.

A Workers' Adviser and staff must have access at any reasonable time to the complete claims files of the Board and any other material relating to the claim of an injured or disabled worker.

A Workers' Adviser and staff must treat the information contained in the claims files as confidential to the same extent as it is so treated by the Board.

C. EMPLOYERS' ADVISERS

The duties of an Employers' Adviser are to:

1. give assistance to an employer respecting any claim under the *Act* of

   (a) a worker of the employer, or

   (b) a dependant of such a worker

   unless the Employers' Adviser considers the claim has no merit;

2. on claims matters, communicate with or appear before the Board and the Workers' Compensation Appeal Tribunal on behalf of an employer if the Adviser considers assistance is required; and

3. advise employers regarding the interpretation and administration of the *Act* or any regulations or decisions made under the *Act*.

An Employers' Adviser and staff have the same right of access to the Board's claim files as a Workers' Adviser and are subject to the same obligation of confidentiality. In addition, section 353(3) of the *Act* specifically provides that "An employers' adviser must not report or disclose to an employer information obtained from or at the Board of a type that would not be disclosed to the employer by the Board."

EFFECTIVE DATE:	Section A is effective June 1, 2009. Sections B and C are effective March 3, 2003.
AUTHORITY:	Sections 350, 351, 352, 353, and 354 of the *Act*.
CROSS REFERENCES:	Item C15-109.10, *Ombudsperson*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #109.00, #109.10, and #109.20, consequential to

reformatting and renumbering policies in Chapter 15, *Advice and Assistance*.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
June 1, 2009 – Deleted references to Adjudicators, Claims Officer, and Board officer.
March 3, 2003 – Changes were made regarding reference to the Workers' Compensation Appeal Tribunal.

APPLICATION: Section A applies on or after June 1, 2009.
Sections B and C apply to all decisions made on or after March 3, 2003.

RE: Ombudsperson **ITEM: C15-109.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the Ombudsperson's authority and the role of the Ombudsperson's office.

2. The Act

None.

POLICY

The Ombudsperson has the right to examine or copy material from claim files in the possession of the Board.

The Board regards the work of the Ombudsperson's office as a forward step in the process of assuring fair and reasonable approaches to matters within the Board's jurisdiction. Full cooperation will therefore be extended to the staff of the Ombudsperson's office in all matters.

AUTHORITY: Section 15 of the *Ombudsperson Act*.

CROSS REFERENCES: Item AP8-349-1, *Disclosure of Assessment Information* ((f) Ombudsperson, Employers' Advisers, Workers' Advisers, Workers' Compensation Appeal Tribunal, MLAs), of the *Assessment Manual*.

HISTORY: December 1, 2025 – This policy resulted from former policy item #109.30, consequential to reformatting and renumbering policies in Chapter 15, *Advice and Assistance*.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

RE: Third Party Claims – Injury Caused by Worker or Employer **ITEM: C16-111.00**

BACKGROUND

1. Explanatory Notes

This policy provides an overview of the provisions of the *Act* related to third party claims, including where an injury is caused by a worker or employer, as well as situations where a worker or employer is partly at fault and a third party outside the compensation provisions of the *Act* may be involved.

2. The Act

Section 127:

(1) Subject to subsection (2),

(a) the compensation provisions are in place of any right and rights of action, statutory or otherwise, founded on a breach of duty of care or any other cause of action, whether that duty or cause of action is imposed by or arises by reason of law or contract, express or implied, to which a worker or a dependant or family member of the worker is or may be entitled against

(i) the employer of the worker,

(ii) an employer within the scope of the compensation provisions, or

(iii) any other worker,

in respect of any personal injury, disablement or death of the worker arising out of and in the course of employment, and

(b) no action lies in respect of such an injury, disablement or death.

(2) Subsection (1) applies only if the action or conduct of

(a) the employer or the employer's servant or agent, or

(b) the other worker,

that caused the breach of duty of care arose out of and in the course of employment within the scope of the compensation provisions.

Section 131:

The following apply if, in an action brought by a worker, by a dependant of a worker or by the Board, it is found that the injury, disablement or death of the worker, as applicable, was due partly to a breach of duty of care of one or more employers or other workers to which the compensation provisions apply:

(a) no damages, contributions or indemnity are recoverable for the portion of the loss or damage caused by the negligence of such an employer or other worker;

(b) the portion of the loss or damage caused by that negligence must be determined despite the employer, other worker or both, as applicable, not being a party to the action.

POLICY

A. GENERAL

A worker who incurs an injury or disease as a result of employment may be entitled to compensation from sources other than the Board. The *Act* makes special provision in Division 3 of Part 3 [Legal Effect of Workers' Compensation System] for injuries or diseases which occur in circumstances entitling the worker to pursue an action for damages against a third party (see also Items C16-111.10, C16-111.11, and C16-111.20).

Injuries occurring outside the province are not generally compensable. Where they are compensable, the *Act* makes special provision for cases where the worker is also entitled to claim compensation in the place of injury (see Items C16-112.00 and C16-112.10).

B. INJURY CAUSED BY WORKER OR EMPLOYER

Section 127 of the *Act* prohibits a lawsuit by an injured worker or a dependant or family member of the injured worker against the employer of the worker, an employer within the scope of the compensation provisions of the *Act*, or any other worker, in respect of any personal injury, disablement or death of the worker arising out of and in the course of employment. The worker or dependant or family member has no choice but to claim compensation. In situations where the third party on a claim is reported to be a worker, it must also be established that the activities of this "worker" were arising out of and in the course of that worker's employment.

i. Employer or Worker Partly at Fault

Section 131 of the *Act* provides that the following apply if, in an action brought by a worker, by a dependant of a worker or by the Board, it is found that the injury, disablement, or death of the worker, as applicable, was due partly to a breach of duty of care of one or more employers or other workers to which the compensation provisions of the *Act* apply:

(a) no damages, contributions or indemnity are recoverable for the portion of the loss or damage caused by the negligence of such an employer or other worker;

(b) the portion of the loss or damage caused by that negligence must be determined despite the employer, other worker or both, as applicable, not being a party to the action.

AUTHORITY: Sections 127 and 131 of the *Act*.

HISTORY: December 1, 2025 – This policy resulted from the consolidation of former policy items #110.00, #111.00, #111.10, and #111.11, consequential to reformatting and renumbering policies in Chapter 16, *Third-Party/Out-of-Province Claims*.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

RE: Third Party Claims – Injury Not Caused by Worker or Employer **ITEM: C16-111.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on third party claims where an injury is not caused by a worker or employer and where the worker can make an election to claim compensation under the *Act* or bring an action against a third party.

2. The Act

Section 121:

For the purposes of the compensation provisions,

(a) a worker who is a minor has the capacity of a person who has reached 19 years of age, and

(b) no other person has a cause of action or right to compensation for the personal injury or disablement of the worker except as expressly provided in the compensation provisions.

Section 127:

(1) Subject to subsection (2),

(a) the compensation provisions are in place of any right and rights of action, statutory or otherwise, founded on a breach of duty of care or any other cause of action, whether that duty or cause of action is imposed by or arises by reason of law or contract, express or implied, to which a worker or a dependant or family member of the worker is or may be entitled against

(i) the employer of the worker,

(ii) an employer within the scope of the compensation provisions, or

(iii) any other worker,

in respect of any personal injury, disablement or death of the worker arising out of and in the course of employment, and

(b) no action lies in respect of such an injury, disablement or death.

(2) Subsection (1) applies only if the action or conduct of

(a) the employer or the employer's servant or agent, or

(b) the other worker,

that caused the breach of duty of care arose out of and in the course of employment within the scope of the compensation provisions.

Section 128:

(1) If the cause of an injury, disablement or death of a worker is such that an action lies against a person, other than an employer or worker within the scope of the compensation provisions, the worker or dependant may

(a) claim compensation under the compensation provisions, or

(b) bring an action.

(2) If a worker or dependant of a worker elects to claim compensation under subsection (1)(a), the worker or dependant must do so within 3 months of the occurrence of the injury, disablement or death of the worker or a longer period that the Board allows.

(3) If the Board is satisfied that

(a) a worker is unable to exercise the worker's right to elect to claim compensation under subsection (1)(a) due to the worker's physical or mental disability, and

(b) undue hardship will result,

the Board may pay the compensation provided under the compensation provisions until the worker is able to make an election.

(4) If, after compensation is paid under subsection (3), the worker then elects not to claim compensation under subsection (1)(a),

(a) no further compensation may be paid, and

(b) the compensation that was paid is a first charge against any amount recovered.

(5) In relation to a minor child of a deceased worker, an application filed by a parent, a guardian or the Public Guardian and Trustee for compensation for the child is a valid election on behalf of that child.

Section 129:

If after trial, or after settlement out of court with the written approval of the Board, less is recovered and collected than the amount of the compensation to which a worker or dependant would be entitled under the compensation provisions, the worker or dependant is entitled to compensation under those provisions to the extent of the amount of the difference.

Section 130, in part:

(1) If a worker or dependant applies to the Board claiming compensation under the compensation provisions, neither the making of the application nor the payment of compensation under those provisions restricts or impairs any right of action against the party liable.

(2) In relation to every claim referred to in subsection (1), the Board is subrogated to the rights of the worker or dependant and may maintain an action in the name of the worker or dependant or in the name of the Board.

…

(4) If, by an action under subsection (2), more is recovered and collected than the amount of the compensation to which the worker or dependant would be entitled under the compensation provisions, the amount of the excess, less costs and administration charges, must be paid by the Board to the worker or dependant.

POLICY

Section 121 provides that a worker under the age of 19 years can make a valid election.

A. FORM OF ELECTION

Any signed notification from a worker or dependant outlining the worker or dependant's decision is a valid election. A Form 6 Application for Compensation and Report of Injury or Occupational Disease could constitute an election. However, to ensure that the worker or dependant is fully aware of the implications of making the election, the Board also provides information regarding the election process, and a specific election to claim compensation form.

B. ELECTION NOT TO CLAIM COMPENSATION

If an injured worker decides to proceed with a lawsuit, no action is taken on the claim by the Board. The worker simply retains a lawyer to prosecute the case.

Section 129 of the *Act* provides that if after trial, or after settlement out of court with the written approval of the Board, less is recovered and collected than the amount of the compensation to which a worker or dependant would be entitled under the compensation provisions of the *Act*, the worker or dependant is entitled to compensation under those provisions to the extent of the amount of the difference.

Therefore, if a worker fails in the lawsuit or is only partially successful, the worker is able to claim the difference from the Board and thereby end up with at least as much as the worker would have received if compensation had been claimed from the Board initially. A question arises as to the meaning of the word "difference". For the purpose of section 129, it will be the actual amount of the judgment or settlement in the claimant's action with no deduction being made for the costs of obtaining the judgment.

The submission of an application to the Board must have been made within the time limits laid down for applications for compensation in order that a subsequent request for the difference can be considered.

C. ELECTION TO CLAIM COMPENSATION

If an injured worker or dependant elects to claim compensation from the Board rather than take their own action, the claim is processed in the usual way and they receive the usual compensation benefits from the Board. They cannot revoke the election after any payment has been made, except by immediate repayment of all monies paid out under the claim.

Under section 128 of the *Act*, a person cannot claim both compensation and pursue a court action. Under section 130, if the person claims compensation, the Board is subrogated to the action. If the person chooses to sue, no compensation benefits are received. There is no right to receive compensation on a temporary basis while pursuing a court action on the understanding that the benefits will be repaid following that action. If, pursuant to section 128, a claimant receives compensation prior to making an election, the compensation is terminated immediately when an election is made not to claim compensation.

An agreement between Canada and British Columbia regarding compensation costs for the injury or death of an emergency volunteer pursuant to the *Emergency and Disaster Management Act* sets out the following pre-conditions before an emergency volunteer can receive compensation. No compensation is payable to the emergency volunteer or legal representative or dependants, as the case may be, unless the emergency volunteer, or legal representative, or dependants:

(a) assigns and subrogates or assign and subrogate to the Workers' Compensation Board their rights against any person against whom any action may lie with respect to the said accident; and

(b) releases or release Canada and B.C. and all its or their officers, servants, agents and employees of the Canadian Armed Forces from any and all liability arising out of or connected with the said accident.

D. ADDITIONAL CONSIDERATIONS

Section 86 of the *Motor Vehicle Act* gives a right of action to a person injured in a motor vehicle accident against the owner of the vehicle in question where it was being driven by a member of the owner's family living under the same roof or any other person driving with the owner's consent. Even though an action against the driver is barred under section 127 of the *Act*, the action against the owner may still lie, with the result that the claimant must make an election under section 128. This could occur, for example, where the owner takes their vehicle to a garage for repair and the accident occurs while it is being test driven by a mechanic.

In determining whether there must be an election under section 128, consideration is given to whether there is a right of action against the manufacturer, designer, etc. of a product which caused the injury. The action against such a person will be barred under section 127 if the person is an employer covered by the *Act*, but not if the person is located outside British Columbia.

AUTHORITY:	Sections 121, 127, 128, 129, 130, and 319 of the *Act*.
CROSS REFERENCES:	Item C7-49.00, *Incapacity of a Worker*; Item C12-93.10, *Application for Compensation*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #111.21, #111.22, #111.23, #111.24, and #111.20, consequential to reformatting and renumbering policies in Chapter 16, *Third-Party/Out-of-Province Claims*. October 1, 2024 – Housekeeping changes consequential to the replacement of the *Emergency Program Act* with the *Emergency and Disaster Management Act* in November 2023, and the repeal of the *Emergency Program Management Regulation* in July 2024, and to update an outdated term. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

RE: Third Party Claims – Pursuing of Subrogated Actions by the Board **ITEM: C16-111.11**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on claims in which the Board is subrogated to the rights of a worker and maintains an action.

2. The Act

Section 130:

(1) If a worker or dependant applies to the Board claiming compensation under the compensation provisions, neither the making of the application nor the payment of compensation under those provisions restricts or impairs any right of action against the party liable.

(2) In relation to every claim referred to in subsection (1), the Board is subrogated to the rights of the worker or dependant and may maintain an action in the name of the worker or dependant or in the name of the Board.

(3) The Board has exclusive jurisdiction to determine whether to maintain an action under this section or compromise the right of action, and the Board's decision is final and conclusive.

(4) If, by an action under subsection (2), more is recovered and collected than the amount of the compensation to which the worker or dependant would be entitled under the compensation provisions, the amount of the excess, less costs and administration charges, must be paid by the Board to the worker or dependant.

Section 133:

(1) In an action brought under this Division [Division 3 of Part 3 – Legal Effect of Workers' Compensation System], an award for damages must include

(a) health care provided under Part 4 *[Compensation to Injured Workers and Their Dependants]*, and

(b) wages and salary paid by an employer during the period of disability

(i) that were considered by the Board in setting the amount of a periodic payment of compensation, or

(ii) that would have been considered by the Board for that purpose if the worker had elected to claim compensation.

(2) Costs may be awarded to and collected by the Board in an action taken by the Board under this Division [Division 3 of Part 3 – Legal Effect of Workers' Compensation System] even if a salaried employee of the Board acts as solicitor or counsel for the Board.

POLICY

Where the Board is subrogated to an action following a claimant's election to claim compensation, the Board has exclusive jurisdiction to determine whether it shall maintain or compromise the right of action, and the decision of the Board is final and conclusive. The Legal Services Division of the Board determines whether there is a cause of action against a third party, and whether it is one that is worth pursuing.

Where the Legal Services Division decides to pursue the claim, conduct of the action is carried within the Legal Services Division, except where an outside counsel is more practicable. Where an outside counsel is retained, the Legal Services Division will carry out the selection and provide written instruction.

The Legal Services Division will not select a lawyer proposed by the claimant. It will be made clear in the written instructions that the outside counsel is acting on behalf of the Board, and that the full recovery is to be paid to the Board, subject to recognition of the lawyer's lien for fees and disbursements. The Board will account to the claimant for any excess.

If the Legal Services Division concludes that there is no claim worth pursuing, but the claimant or the claimant's lawyer disagrees, the claimant may be permitted to select a lawyer to conduct an action and the lawyer will be advised:

(a) that the action is one the Legal Services Division does not consider worth pursuing;

(b) that if the lawyer is of a different opinion, the lawyer may be authorized to pursue an action on behalf of the Board and the claimant on the terms that if there is a successful recovery, the full recovery is to be paid to the Board, subject to recognition of a lien for fees and disbursements; further, that if the action is not successful, the Board will not be responsible for fees and disbursements;

(c) of the amount of the Board's claim or, if that is not possible, of an indication that the amount of the Board's claim remains to be determined.

This procedure will not be followed where it is felt that the risk of liability for costs clearly exceeds any likelihood of recovery.

Where action is taken by the Board, a claim is advanced which includes not only the disbursements paid out on the claim by the Board, but all items or damages which the claimant could have recovered if action had been taken on the claimant's own. Section 133(1) of the *Act* provides that in an action brought under Division 3 of Part 3 [Legal Effect of Workers' Compensation System], an award for damages must include

(a) health care provided under Part 4 [Compensation to Injured Workers and Their Dependants], and

(b) wages and salary paid by an employer during the period of disability

(i) that were considered by the Board in setting the amount of a periodic payment of compensation, or

(ii) that would have been considered by the Board for that purpose if the worker had elected to claim compensation.

The mere fact that in a court action the Board has claimed damages for a particular item does not mean that that item has been accepted as part of the claimant's compensation claim.

Section 130(4) of the *Act* provides:

> If, by an action under subsection (2), more is recovered and collected than the amount of the compensation to which the worker or dependant would be entitled under the compensation provisions [of the *Act*], the amount of the excess, less costs and administration charges, must be paid by the Board to the worker or dependant.

Thus, if the action is successful, the Board's disbursements, i.e. all monies paid out under the claim (wage-loss benefits, permanent disability benefits, health care benefits, administration costs, etc.) are deducted from the amount recovered and the excess is then paid to the claimant or dependant. If the action is not successful, all costs are paid by the Board.

When the excess has been paid to the claimant, and the claim is reopened at a future date, the excess paid will be taken into consideration before any further payment of compensation is made on the claim.

An agreement between Canada and British Columbia regarding compensation costs for the injury or death of an emergency volunteer pursuant to the *Emergency and Disaster Management Act* sets out particular rules applicable to an action that is pursued for an accident experienced by an emergency volunteer.

Where the Board is unsuccessful either in total or in part in recovering damages from a third party and the third party has an entitlement to benefits from the Board, the recovery will be made from such benefits. If there is no existing entitlement to benefits, a record of the indebtedness will be made by the Board and should any future entitlement to benefits accrue, a recovery will be made from that entitlement. As a general guideline, this recovery will follow the limits set out in the *Court Order Enforcement Act*. Such limitations would not apply in the case of permanent disability benefits where the indebtedness may be recovered from the permanent disability capital reserve.

AUTHORITY: Sections 130 and 133 of the *Act*.

HISTORY: December 1, 2025 – This policy resulted from the consolidation of former policy items #111.25 and #111.26, consequential to reformatting and renumbering policies in Chapter 16, *Third-Party/Out-of-Province Claims*.
October 1, 2024 – Housekeeping changes consequential to the replacement of the *Emergency Program Act* with the *Emergency and Disaster Management Act* in November 2023, and the repeal of the *Emergency Program Management Regulation* in July 2024.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

RE: Third Party Claims – Other Matters **ITEM: C16-111.20**

BACKGROUND

1. Explanatory Notes

This policy sets out the definitions of "worker" and "employer" in relation to third party claims and provides guidance on Federal Government employees in relation to third party claims.

2. The Act

Section 126:

> For the purposes of this Division [Division 3 of Part 3 – Legal Effect of Workers' Compensation System]:
>
> **"person"** includes the personal representative of a person;
>
> **"worker"** includes an employer to which the compensation provisions apply by direction under section 4(2)(b) *[Board direction]*.

POLICY

A. MEANING OF "WORKER" AND "EMPLOYER" UNDER DIVISION 3 OF PART 3 OF THE *ACT*

In the provisions discussed in policy in Items C16-111.00 and C16-111.10, "worker" and "employer" have the meaning given to them in Chapter 2.

Section 126 defines "worker" for the purposes of Division 3 of Part 3 of the *Act* [Legal Effect of Worker's Compensation System] to include an employer to whom the Board has directed that the compensation provisions of the *Act* are to apply, as if the employer were a worker entitled to Personal Coverage.

However, this does not affect status as an employer under this Division in regard to other workers.

The meanings of "employer", "worker", and "employment" for the purpose of Division 3 of Part 3 of the *Act* in claims concerning commercial fishers are discussed in section 14 of the *Fishing Industry Regulations*.

B. FEDERAL GOVERNMENT EMPLOYEES

The provisions discussed in policy in Items C16-111.00, C16-111.10, C16-111.11, and Section A of this Item have no application to employees entitled under the *Government Employees Compensation Act* ("*GECA*").

Rules similar to those set out in policy in Items C16-111.00, C16-111.10, C16-111.11, and Section A of this Item are set out in section 9 of the *GECA*. In general, the claimant is precluded from suing the government in respect of an employment accident, but must claim compensation. Where the circumstances of the accident give rise to a right of action against someone other than the government, the claimant must elect either to sue that other person or claim compensation. If the claimant does the latter, the government is subrogated to the right of action. These subrogated actions are administered by the Federal Government directly. The Board is not concerned in them.

EFFECTIVE DATE: Section A is effective March 18, 2003.
AUTHORITY: Section 126 of the *Act*.
HISTORY: March 2, 2026 – Housekeeping change to update the term "Personal Optional Protection" to "Personal Coverage."
December 1, 2025 – This policy resulted from the consolidation of former policy items #111.30 and #111.50, consequential to reformatting and renumbering policies in Chapter 16, *Third-Party/Out-of-Province Claims*.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
March 18, 2003 – Deleted reference to the *Workers' Compensation Reporter* Decision No. 223.

RE: Injuries Occurring Outside British Columbia **ITEM: C16-112.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on compensation provided to workers for injuries occurring outside British Columbia.

2. The Act

Section 134(1):

> If, in an industry within the scope of the compensation provisions, personal injury or death arising out of and in the course of a worker's employment is caused to the worker, compensation as provided under this Part must be paid by the Board out of the accident fund.

Section 147:

(1) This section applies if

(a) a worker is injured while working outside British Columbia, and

(b) the injury would entitle the worker or the worker's dependants to compensation under this Part if the injury occurred in British Columbia.

(2) The Board must pay compensation under this Part only if all of the following apply:

(a) a place of business of the worker's employer is located in British Columbia;

(b) the worker's residence and usual place of employment are located in British Columbia;

(c) the employment is such that the worker is required to work both in and outside British Columbia;

(d) the worker's employment outside British Columbia

(i) has immediately followed the worker's employment in British Columbia by the same employer, and

(ii) has lasted less than 6 months.

POLICY

A. INTRODUCTION

Section 134(1) of the *Act* provides in part that compensation is payable where ". . . personal injury or death arising out of and in the course of a worker's employment is caused to a worker . . ." It places no limitation on the place of injury. On the face of it, it might be held to apply to all employment injuries, whether they occur inside or outside British Columbia. The Board has, however, concluded that the section could not be intended to have such a broad effect. The *Act* only applies to injuries occurring outside British Columbia where its provisions expressly provide for this, or do so by necessary implication. There are two main situations that have to be considered, which are discussed in policy in Sections B and C of this Item.

The payment of health care benefits for costs incurred outside British Columbia is discussed in policy in Item C10-75.10.

B. WORKER IS WORKING OUTSIDE BRITISH COLUMBIA

Section 147 does not apply to commercial fishers.

i. Meaning of Working in Section 147

Section 147 of the *Act* only applies if "a worker is injured while working outside British Columbia…".

In a Board decision, a worker who lived in the province of Alberta was employed by an employer located in British Columbia. Each day, he travelled into British Columbia to come to work on a bus provided by his employer. He was injured in an accident in which this bus was involved while still on the Alberta side of the border. It was decided that he was at the time of his injury working in British Columbia rather than Alberta with the result that section 147 had no application.

The Board has on prior occasions, when discussing the meaning of the phrase "arising out of and in the course of a worker's employment" in section 134(1), pointed out that compensation coverage was not limited to "work" in the sense of productive activities. The *Act* covers a much broader range of productive and non-productive activities which comprises a worker's "employment". This distinction between "employment" and "work" activities is also material when interpreting section 147. The place where a person performs the productive, as opposed to the non-productive, activities of the person's

employment is generally the best indicator of where the person works. If someone were to ask the worker in the example above where he worked, he would no doubt have stated that he worked at the person's employer's plant in British Columbia, because that is where his main job function was carried out. The answer would be no different just because part of his journey to work took place in Alberta or, in another case, because the worker was required to perform some incidental job function outside British Columbia. Under this interpretation, the concern is not with the particular activity being carried on at the moment of injury, but the place where the worker performs the major job functions with which that activity is associated.

In other cases, the interpretation of section 147 adopted above may raise difficult questions as to whether a worker's main job function at the time in question is in British Columbia or elsewhere. There will be less obvious cases where the worker is performing significant amounts of productive work activity both inside and outside British Columbia. Since section 147 clearly contemplates that there will be periods of work outside British Columbia where the worker does have to meet the criteria it lays down, it will be necessary to draw a line in these cases between productive activities which are merely incidental to "working" in British Columbia and productive activities which are sufficient to constitute "working outside British Columbia".

In making this judgment, regard will primarily have to be taken of the length of time for which the productive activity is performed outside British Columbia. If the period of absence is less than one day, it will probably, in most cases, be safe to say that the activity is simply incidental to the work performed in British Columbia. On the other hand, where the length of time is greater than a week, it would probably have to be concluded that the worker was "working outside British Columbia".

Periods of between a day and a week would probably have to be dealt with on the individual merits, having regard, in particular, to the nature and circumstances of the worker's employment.

Another factor that must be considered is the degree of regularity with which a worker does productive work outside British Columbia. The more regularly this is done, the shorter is the period of productive work outside British Columbia which would be sufficient for the worker to be considered as "working outside British Columbia". For example, even though the period out of British Columbia is less than a day, the worker might be held to be working outside British Columbia if this was done routinely.

ii. Residence and Usual Place of Employment

Section 147 was intended to provide a convenient and efficient form of coverage for industries which, although normally based in British Columbia, may occasionally require assignment of workers to locations outside British Columbia. Taken as a whole, the section contemplates the coverage of workers who live in British Columbia, who spend the greater part of their time performing a particular kind of work in British Columbia, but

who are assigned for limited periods of time by the same employer and for the same work to other jurisdictions. It was not intended to cover situations where, although there is a place of business of the employer in British Columbia, virtually all of that company's work takes place outside of British Columbia and is performed, for the most part, by employees who neither live nor work in British Columbia.

While it is impossible to lay down specific rules and guidelines for the words "residence and usual place of employment", they must be defined in relation to the broader view of the section as outlined above.

For British Columbia to qualify as the residence and usual place of employment of a worker under section 147, the evidence must reveal more than short-term transient accommodation and must show that the work performed in British Columbia is more consistent and long-term than that performed in the other jurisdiction(s) in question.

In a Board decision, the worker's employer had its head office and base of operations in British Columbia. The worker underwent a two-week training period at the head office, but all his work was outside British Columbia. The worker lived primarily in Ontario and had rented no accommodation in British Columbia during his two-week stay. He did, however, have a bank account here. He was injured in Washington State. His claim was denied because his "residence" and "usual place of employment" were not in British Columbia.

iii. Worker's Employment Outside British Columbia

Upon first reading, section 147(2)(d) appears to require that the injury must occur in the jurisdiction to which the worker has gone directly from British Columbia. However, it does no more than recognize that there exists two classes of employment, those "in British Columbia" and those "outside British Columbia". It requires that the worker's employment outside British Columbia must last less than six months and must immediately follow the worker's employment in British Columbia by the same employer; but it makes no reference to where, outside British Columbia, the employment may take the worker.

As long as the other criteria of the section are met, no objection to a claim should be taken on the basis that a worker went from British Columbia to another jurisdiction and then on to a second or third jurisdiction before the injury occurred. As long as the injury was within the six months and employment was with the same employer, the provisions of the subsection are met.

The word "immediately" would, by normal reference to dictionary definitions, refer to considerations of time. However, because of the nature of the entire section, it is possible to view the term in relation to employment as well. For example, a worker may be employed by a particular employer in British Columbia, leave and go to work for another employer for a short period of time, and then return to the original employer but

hiring on in another jurisdiction. In that case, the worker's employment in British Columbia by the same employer will not have been immediately prior to going to the other jurisdiction and the worker would be barred from a claim for compensation by the subsection. On the other hand, if the worker were to work for an employer within British Columbia and, due to the absence of any further employment prospects, be laid off and then hired on again within British Columbia with the same employer and be assigned immediately to work in another jurisdiction, it could reasonably be concluded that by having worked for the same employer and no one else, and by having been hired in British Columbia, albeit to work only in another jurisdiction, the requirements of the subsection had been met.

C. WORKER IS WORKING IN BRITISH COLUMBIA

The decision discussed in Section B.i of this Item provides an example of when a worker might be working in British Columbia but yet injured outside British Columbia while in the course of the worker's employment. Though the provisions of section 147 of the *Act* were not applicable to that claim, it was decided that the claim could be accepted under section 134(1).

Where there is an injury outside British Columbia, the first question that must be asked is where, at the time in question, the worker was performing the worker's main job functions. The concern will not be with the particular activity being engaged in at the moment of the injury. If the worker's main job at the time is being performed outside of British Columbia, the claim must satisfy the requirements of section 147, including the requirement that the worker be a resident of British Columbia. If those functions are being performed in British Columbia, the worker only has to meet the requirements of section 134(1) and section 147 has no application. Since the main job function of the worker in this decision was in British Columbia at the time of his injury and his injury did arise out of and in the course of his employment, his claim was an acceptable one even though he did not reside in British Columbia.

AUTHORITY:	Sections 8, 134, and 147 of the *Act*. Section 4 of the *Fishing Industry Regulations*, B.C. Reg. 674/76.
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and in the Course of a Worker's Employment*, of the *Rehabilitation Services & Claims Manual*, Volume II. Item AP1-8-1, *Fishing*; Item AP5-245-2, *Payroll – Out of Province Employers and Operations*, of the *Assessment Manual*.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #112.00, #112.10, #112.11, #112.12, #112.13, and #112.20, consequential to reformatting and renumbering policies in Chapter 16, *Third-Party/Out-of-Province Claims*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

RE: Entitled to Compensation Outside British Columbia ITEM: C16-112.10

BACKGROUND

1. Explanatory Notes

This policy provides guidance on situations where workers may be entitled to compensation for injuries occurring outside British Columbia by the law of the place in which the injury occurred, as well as guidance on Federal Government employees.

2. The Act

Section 148:

(1) This section applies if, by the law of the country or place in which a worker's injury or occupational disease occurred, the worker or the worker's dependants are entitled to compensation in respect of the injury or occupational disease.

(2) The worker or the worker's dependants must

(a) elect whether they will claim compensation

(i) under the law of the country or place referred to in subsection (1), or

(ii) under this Part, and

(b) give notice of the election.

(3) Notice of the election required under subsection (2) must be given to the Board as follows:

(a) unless paragraph (b) of this subsection applies, within 3 months after the occurrence of the injury or disablement from occupational disease;

(b) if the injury or occupational disease results in death,

(i) within 3 months after the death, or

(ii) within a longer period that the Board allows before or after the expiration of the 3 months.

(4) If the required election is not made and notice not given, it must be presumed that the worker or the worker's dependants have elected not to claim compensation under this Part.

(5) If an agreement or arrangement under section 335 *[interjurisdictional agreements and arrangements]* applies, any right of election is subject to the terms of that agreement or arrangement.

POLICY

The right of election under section 148 of the *Act* is subject to the terms of any interjurisdictional agreement.

In addition to the Form 6 Application for Compensation and Report of Injury or Occupational Disease that is required, the worker or the worker's dependants can provide election notice by the specific election-to-claim-compensation form that the Board provides with information regarding the election process. A claim for compensation, made to the Workers' Compensation Board of the place outside British Columbia where the injury or exposure to the causes of an occupational disease occurs, constitutes an election to claim under the law of that place.

A. OCCUPATIONAL DISEASE

It may happen that the occupational disease a worker has is due to exposure in the course of the worker's employment both inside and outside British Columbia. If the exposure within British Columbia is not significant, the Board will not accept responsibility for the claim, subject to the terms of any interjurisdictional agreement. If the exposure within British Columbia is significant, the Board will accept responsibility of the whole of the worker's occupational disease. There will, in general, be no apportionment of liability. The worker may, however, be required to elect to claim in British Columbia under section 148 of the *Act*. Where the Board is accepting full responsibility for the occupational disease, the worker cannot claim in both British Columbia and another province or territory.

An exception exists for hearing-loss claims. As discussed in Section C of Item C4-31.00, liability will be apportioned where more than 5% but under 90% of the worker's exposure was outside British Columbia.

B. FEDERAL GOVERNMENT EMPLOYEES

Federal Government employees must claim compensation in the province where they are usually employed regardless of the place of injury.

AUTHORITY:	Section 148 of the *Act*.
CROSS REFERENCES:	Item C3-12.10, *Entitlement for Federal Government Employees*; Item C4-31.00, *Hearing Loss* (Section C. Amount and Duration of Noise Exposure Required by Section 145); Item C17-115.10, *Interjurisdictional Agreements*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #112.30, #112.31, and #112.40, consequential to reformatting and renumbering policies in Chapter 16, *Third-Party/Out-of-Province Claims*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

RE: Charging Claim Costs – General **ITEM: C17-113.00**

BACKGROUND

1. Explanatory Notes

This chapter of the *Manual* sets out policies related to the charging of claim costs. This policy provides introductory guidance on how the Board charges claim costs and sets out general principles, including general principles related to experience rating (ER).

Generally, the costs of a claim are charged to the rate group of the employer. This chapter sets out policies which provide guidance on circumstances where claim costs may not be charged to the rate group of an employer.

The Board has also adopted an ER plan under section 247 of the *Act*. The ER plan adjusts an employer's assessment rate in response to its claim costs experience. Sometimes, certain claim costs are excluded from consideration for ER purposes. This chapter sets out policies detailing ER exclusions.

Additional information on the ER plan can be found in the *Assessment Manual*.

2. The Act

Section 247, in part:

> (1) The Board must establish subclassifications, differentials and proportions in the rates as between the different kinds of employment in the same class, as the Board considers just.
>
> (2) If the Board considers that a particular industry or plant is circumstanced or conducted such that the hazard or cost of compensation differs from the average of the class or subclass to which the industry or plant is assigned, the Board
>
> (a) must establish a special rate, differential or assessment for that industry or plant to correspond with the relative hazard or cost of compensation of the industry or plant, and
>
> (b) for the purpose referred to in paragraph (a), may also adopt a system of experience rating.
>
> …

POLICY

The general practice followed by the Board is that the cost of any compensation paid out on a claim is charged to the class or subclass of employers of which the worker's employer is a member. These costs are not paid directly by the employer. Rather, the employer will, through the assessment rate, pay a proportion of the total costs incurred on all claims made by employees of all the employers in the subclass. The proportion paid is the proportion which the employer's payroll bears to the total payrolls of all employers in the subclass. This may be adjusted through a system of experience rated assessments.

In certain cases, the class or subclass consists of one major employer so that the employer does directly pay the costs of the claim. Examples are the Canadian National Railway, Air Canada, Canadian Pacific Railway Limited, and the Government of British Columbia. These are termed deposit classes.

Generally speaking, whether or not an employer was at fault is not a material factor when determining how the costs of a claim are to be charged. The general practice set out above applies both when the employer's negligence or misconduct caused an injury and when the injury was due to circumstances beyond the employer's control.

There are certain provisions in the *Act* which result in exceptions to the above rule. An individual employer or the class or subclass may be relieved of the costs of compensation incurred on a particular claim. Alternatively, an individual employer may be charged with costs additional to the employer's ordinary liability as a member of a class or subclass. None of these special relieving or charging provisions apply to claims by Federal Government employees.

The amount of costs attributed to an employer are disclosed to an employer in the cost statements which are sent regularly. These list the claims concerned and the amount of costs incurred on each.

EFFECTIVE DATE: October 21, 2020

HISTORY: December 1, 2025 – This policy resulted from former policy item #113.00, consequential to reformatting and renumbering policies in Chapter 17, *Charging of Claim Costs*.
October 21, 2020 – Amended to reflect amendments to the *Act* by the *Workers Compensation Amendment Act, 2020* (Bill 23 of 2020), in effect August 14, 2020.
December 31, 2003 – Changes were made to the third paragraph of this policy which incorporated portions of, and replaced, policy item #115.20, *Significance of Employer's Conduct in Producing Injury*, of the *Rehabilitation Services & Claims Manual*, Volume II.

APPLICATION: Applies on or after October 21, 2020.

RE: Experience Rating Cost Exclusions **ITEM: C17-114.00**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the ER plan under section 247 of the *Act* and sets out the types of claim costs that are excluded from ER consideration.

2. The Act

Section 247:

(1) The Board must establish subclassifications, differentials and proportions in the rates as between the different kinds of employment in the same class, as the Board considers just.

(2) If the Board considers that a particular industry or plant is circumstanced or conducted such that the hazard or cost of compensation differs from the average of the class or subclass to which the industry or plant is assigned, the Board

(a) must establish a special rate, differential or assessment for that industry or plant to correspond with the relative hazard or cost of compensation of the industry or plant, and

(b) for the purpose referred to in paragraph (a), may also adopt a system of experience rating.

(3) The Board may, in a manner that the Board determines,

(a) vary the rates of assessment as between different employers, or

(b) levy supplementary assessments

according to the estimated exposure of workers to industrial noise.

(4) The Board may make that variance or levy under subsection (3) whether or not hearing protection is worn.

POLICY

The Board has adopted an ER plan under section 247 of the *Act*. The plan compares the ratio between an employer's claim costs and assessable payroll with the ratio between the total claim costs and assessable payroll of the employer's rate group. Subject to maximums, discounts are assigned for favourable ratios and surcharges for unfavourable ratios. The discount or surcharge takes the form of a percentage increase or decrease in the usual assessment rate. Details of the ER plan can be found in the policy in Item AP5-247-1 of the *Assessment Manual*.

As a general rule, all acceptable claims coded to a particular employer are counted for ER purposes. It makes no difference whether the injury was or was not the employer's fault. There are, however, some types of claim costs which are excluded from consideration. These are:

1. Costs recovered by way of a third party action (see Item C16-111.11).

2. Investigation and/or compensation costs paid out prior to the disallow of a claim or reversal of a decision by the Board, or the Workers' Compensation Appeal Tribunal (see Item C17-114.10).

3. Costs transferred to the rate group of another employer under section 249 (see Item C17-114.20).

4. Costs assigned to the funds created by sections 240(1)(c) and 240(1)(d) (see Items C17-114.30 and C17-114.40).

5. Occupational disease claims which on average require exposure for, or involve latency periods of, two or more years before manifesting into a disability. The diseases presently excluded on this ground are:

    - Non-traumatic hearing loss, excluding hearing loss resulting from other injuries
    - Silicosis
    - Asbestosis
    - Other diagnosed pneumoconioses, for example, anthracosis and siderosis
    - Pneumoconioses not specifically diagnosed
    - Heart disease
    - Cancer
    - Hand-arm vibration syndrome, vinyl chloride induced Raynaud's phenomenon, disablement from vibrations

    (see Item C17-114.50).

6. Costs where section 134(2) applies (see Item C3-14.10).

7. Costs from accidents substantially due to personal illness, e.g. epilepsy (see Item C3-16.00).

8. Injuries covered by Items C11-88.10, C11-88.40, and C11-88.50.

9. The situation covered by policy in Item C17-114.60.

10. The costs of certain compensable consequences that occur at a place, or en route to or from a place, of treatment, surgery, or Board-related assessment, as set out in policy in Item C17-114.70.

11. The situations covered by policy in Items C17-114.80 and C17-114.90.

The decision whether a claim falls within one of the exclusions will usually be made by the Board. In the case of third party actions (Exclusion 1), a Board solicitor makes the decision.

EFFECTIVE DATE: June 1, 2022

AUTHORITY: Section 247 of the *Act*.

CROSS REFERENCES:
Item C3-14.10, *Serious and Wilful Misconduct*;
Item C3-16.00, *Pre-Existing Conditions or Diseases*;
Item C11-88.10, *Vocational Rehabilitation − Work Assessments*;
Item C11-88.40, *Vocational Rehabilitation − Training-on-the-Job*;
Item C11-88.50, *Vocational Rehabilitation − Formal Training*;
Item C16-111.11, *Pursuing of Subrogated Actions by the Board*;
Item C17-114.10, *Investigation Costs*;
Item C17-114.20, *Transfer of Costs to Another Class for Serious Breach of Duty of Care*;
Item C17-114.30, *Funds under Sections 240(1)(b) and 240(1)(c)*;
Item C17-114.40, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*;
Item C17-114.50, *Charging Costs of Occupational Disease and Hearing Loss Claims*;
Item C17-114.60, *Injuries or Aggravations in the Course of Medical Treatment, Appointments and Related Travel*;
Item C17-114.70, *Certain Compensable Consequences*;
Item C17-114.80, *Subsequent Non-Compensable Incidents*;
Item C17-114.90, *Claims Involving a Permanent Disability and a Fatality*, of the *Rehabilitation Services & Claims Manual*, Volume II.
Item AP5-247-1, *Experience Rating*, of the *Assessment Manual*.

HISTORY:
December 1, 2025 – This policy resulted from former policy item #115.30, consequential to reformatting and renumbering policies in Chapter 17, *Charging of Claim Costs*.
January 1, 2023 – Housekeeping amendment.
June 1, 2022 – Policy amended to update claim costs to be excluded from consideration for experience rating purposes as set out in Item C3-14.10, *Serious and Wilful Misconduct*.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
January 1, 2016 – Policy amended to add new type of claim costs to be excluded from consideration for experience rating purposes, as set out in

former policy item #115.34, *Experience Rating Exclusions for Certain Compensable Consequences*.
August 1, 2010 – Consequential amendments to address whether an employer should receive cost relief where a worker continues to receive temporary wage-loss benefits for a compensable disability when a subsequent non-compensable incident delays the worker's recovery from the compensable disability.
June 1, 2009 – Deleted references to the Review Division, Medical Review Panel and the Worker and Employer Services Division.
March 1, 2005 – Updated language as to the use of the phrase "rate group", consistent with rate-making system in *Assessment Manual*; updated and incorporated cross-references to then policy item #113.20 and Item C11-88.10, to make all items consistent and accurate. This policy continues the substantive requirements as they existed prior to the effective date. Applied to all decisions on or after March 1, 2005.
March 18, 2003 – "Discount", "Surcharge" and the numerical reference to the policy in then Item AP1-42-1 in the *Assessment Manual* were incorporated.

APPLICATION: This policy applies to all decisions, including appellate decisions, made on or after June 1, 2022.

RE: Investigation Costs **ITEM: C17-114.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on situations where costs are incurred while the validity of a claim is being investigated or benefits are being provided pursuant to an interim adjudication.

2. The Act

None.

POLICY

Costs may be incurred prior to making a decision on a claim in investigating the validity of the claim or in paying benefits pursuant to an interim adjudication. Where the decision is ultimately in the worker's favour, these costs are charged to the employer's class in the normal way. Where the decision is unfavourable to the worker, these costs will not be charged to the employer's class, but will be spread across all classes. They are treated in effect as an administration cost.

The same rule also applies where:

1. A claim is accepted in error or benefits paid in error;

2. A decision is reversed by the Review Division or Workers' Compensation Appeal Tribunal;

3. There is a reconsideration by the Board.

The employer's class is relieved where the original decision was favourable to the worker and benefits were paid pursuant to it. Conversely, the class will be charged with costs already incurred where the previous decision was unfavourable to the worker.

For another situation where the class of employers is relieved of costs as investigation costs, see the policy in Item C4-25.10 regarding having an occupational disease.

EFFECTIVE DATE:	June 1, 2009
CROSS REFERENCES:	Item C4-25.10, *Has a Designated or Recognized Occupational Disease*; Item C17-114.00, *Experience Rating Cost Exclusions*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from former policy item #113.10, consequential to reformatting and renumbering policies in Chapter 17, *Charging of Claim Costs*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted references to Medical Review Panel, officer, Manager and Director. March 3, 2003 – Inserted reference to the Review Division, the Workers' Compensation Appeal Tribunal and to reconsideration by a Manager or Director.
APPLICATION:	Applies on or after June 1, 2009.

RE:	Transfer of Costs to Another Class for Serious Breach of Duty of Care	ITEM:	C17-114.20

BACKGROUND

1. Explanatory Notes

This policy provides guidance on when costs may be partially or fully transferred from the rate group of an accident employer to the rate group of another employer in situations involving a serious breach of duty of care under section 249 of the *Act*.

2. The Act

Section 249:

(1) This section applies if the Board considers that

(a) a substantial amount of compensation has been awarded as a result of the injury or death of a worker, and

(b) the injury or death was caused or substantially contributed to by a serious breach of duty of care of

(i) an employer, or

(ii) an independent operator to whom the compensation provisions apply by Board direction under section 4(2)(a)

that is in a different class or subclass from that of the worker's employer.

(2) The Board may order that the compensation be charged, in whole or in part, to the class or subclass of an employer referred to in subsection (1)(b)(i) or an independent operator referred to in subsection (1)(b)(ii).

POLICY

A. INTRODUCTION

Section 249 of the *Act* permits the Board to transfer the costs of a claim from the class of the worker's employer to the class of another employer in certain circumstances. The requirements of such a transfer are discussed below.

B. THE AMOUNT OF COMPENSATION AWARDED MUST BE SUBSTANTIAL

The Board has interpreted the word "substantial" as referring to a specific dollar amount. The amounts are set out below:

January 1, 2025 – December 31, 2025	$60,935.82
January 1, 2026 – December 31, 2026	$62,253.96

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

Effective June 30, 2002, the dollar amount will be adjusted on January 1 of each year. The percentage change in the consumer price index determined under section 333 of the *Act*, as described in Item C7-51.00, will be used.

C. SERIOUS BREACH OF DUTY OF CARE OF ANOTHER EMPLOYER MUST HAVE CAUSED OR SUBSTANTIALLY CONTRIBUTED TO INJURY

"Duty of care" has the same meaning as it does in the law of tort. It is therefore relevant to consider what conclusions a court of common law would come to if a claim for damages for personal injury were brought by the worker against the other employer. The basic question considered is whether there was a failure to take reasonable care. The mere fact that the employer may have violated the *Occupational Health and Safety Regulation* is not sufficient since it often imposes strict liability.

The doctrine of vicarious liability has no application to section 249 of the *Act*, and a transfer of costs is only available if the breach of duty of care consisted of acts or omissions by management personnel who can be identified as the employer, and not to cases where the breach of duty consists only of the act or omissions of other workers.

If there has been a breach of duty of care by the employer, the next question to be considered is whether it was a "serious" one. The word "serious" refers to the culpability of the employer's behaviour rather than the consequences of that behaviour. Regard will be had to the probability of injury resulting from the breach and the predictable gravity of the likely consequences of such an injury.

The fact that the worker was negligent does not necessarily mean that the employer's breach of duty did not cause or substantially contribute to the injury. Lapses of attention are a normal part of ordinary human behaviour that should be foreseen and guarded against.

D. DISCRETION OF THE BOARD

The Board has discretion, if the requirements set out in policy in Sections A to C are satisfied, to transfer all or part of the cost of a claim. In exercising this discretion, the Board takes no account of any contributory negligence by the worker.

AUTHORITY: Section 249 of the *Act*.

CROSS REFERENCES: Item C7-51.00, *Cost of Living Adjustments to Periodic Payments*; Item C17-114.00, *Experience Rating Cost Exclusions*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY: December 1, 2025 – This policy resulted from the consolidation of former policy items #114.00, #114.10, #114.11, #114.12, and #114.13, consequential to reformatting and renumbering policies in Chapter 17, *Charging of Claim Costs*.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

RE: Funds under Sections 240(1)(b) and 240(1)(c) **ITEM: C17-114.30**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on when certain claim costs may be transferred from the rate group of an employer to the funds created under sections 240(1)(b) and 240(1)(c) of the *Act*.

2. The Act

Section 240(1), in part:

> For the purpose of assessment under section 241, the Board must every year make an estimate of sufficient funds to do the following:
>
> …
>
> (b) provide a reserve in aid of industries or classes which may become depleted or extinguished;
>
> (c) provide a reserve to be used to meet the loss arising from a disaster or other circumstance that the Board considers would unfairly burden the employers in a class;
>
> …

POLICY

A. DEPLETION OR EXTINCTION OF INDUSTRIES OR CLASSES

Section 240(1)(b) of the *Act* requires the Board to "provide a reserve in aid of industries or classes which may become depleted or extinguished".

Employers may apply to have the costs of a claim transferred from their class to that fund. This provision is very rarely used.

B. DISASTER OR OTHER CIRCUMSTANCE THAT UNFAIRLY BURDENS A RATE GROUP

Section 240(1)(c) of the *Act* requires the Board to "provide a reserve … to meet the loss arising from a disaster or other circumstance that the Board considers would unfairly burden the employers in a class".

Costs will not be charged to the fund created by section 240(1)(c) because there is an unfair burden on an individual employer. The unfair burden must be on a rate group or industry group of employers.

Each deposit account employer forms a classification unit, which is treated as a self-funded rate group by itself. This does not automatically mean that a burden on the deposit account employer is a burden on the rate group. The relief available to deposit accounts under section 240(1)(c) is limited to the same sorts of situations as for other employers.

The Federal Government does not contribute to the Accident Fund, therefore no relief of costs under this section can be made where the Federal Government is recorded as the injury employer.

EFFECTIVE DATE:	Section B is effective March 1, 2005.
AUTHORITY:	Section 240 of the *Act*.
CROSS REFERENCES:	Item C17-114.00, *Experience Rating Cost Exclusions*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #114.20 and #114.30, consequential to reformatting and renumbering policies in Chapter 17, *Charging of Claim Costs*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. March 1, 2015 – Updated language consistent with rate-making system in *Assessment Manual*; incorporated portions of, and replaced, then policy item #114.50, *Sections 39(1)(d), 39(1)(e) and Federal Government Claims*, of this *Manual*. This policy continues the substantive requirements as they existed prior to the effective date.
APPLICATION:	Section B applies to all decisions made on or after March 1, 2005**.**

RE: Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability **ITEM: C17-114.40**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on when costs of that portion of a worker's disability enhanced by reason of a pre-existing disease, condition or disability are transferred from the rate group of the employer to the fund created under section 240(1)(d) of the *Act* and also excluded from ER consideration.

2. The Act

Section 240(1), in part:

> For the purpose of assessment under section 241, the Board must every year make an estimate of sufficient funds to do the following:
>
> …
>
> (d) provide and maintain a reserve for payment of that portion of the disability enhanced by reason of a pre-existing disease, condition or disability;
>
> …

POLICY

A. OVERVIEW

Section 240(1)(d) of the *Act* requires the Board to "provide and maintain a reserve for payment of that portion of the disability enhanced by reason of a pre-existing disease, condition or disability". Under this section, eligible claims costs are redirected from an employer's ER and rate group to the section 240(1)(d) reserve.

The intent of section 240(1)(d) is to give reassurance to potential employers that in employing workers with pre-existing diseases, conditions or disabilities, they will not incur undue costs in respect of possible future injuries that are enhanced as a result of the pre-existing diseases, conditions or disabilities.

If a claim is accepted under the *Act* for a personal *injury*, mental disorder or occupational disease, the Board provides cost relief under section 240(1)(d) for any

portion of a compensable *disability* that is enhanced by reason of a pre-existing disease, condition or disability. Section 240(1)(d) cost relief decisions do not impact a worker's entitlement to compensation.

The Board is responsible for initiating section 240(1)(d) cost relief considerations with or without a specific request or application by an employer, and to decide upon the applicability of the section on a claim.

This policy applies to all employers, including deposit class employers, except for the Federal Government. As the Federal Government does not contribute to the Accident Fund, no relief of costs under this section can be made where the Federal Government is recorded as the injury employer.

i. Eligibility

Cost relief consideration does not occur on claims where wage loss ended and/or permanent disability benefits were established on or before December 31, 1993.

Where benefits were paid between January 1, 1994 and September 27, 2002, an employer was eligible for cost relief consideration under now section 240(1)(d) in two situations:

a) on all claims where there had been 13 or more weeks of temporary total and/or temporary partial disability benefits paid;

b) permanent disability benefit had been granted.

Where benefits are paid on or after September 28, 2002, an employer is eligible for cost relief consideration under section 240(1)(d) in two situations:

a) on all claims where there had been 10 or more weeks of temporary total and/or temporary partial disability benefits paid;

b) permanent disability benefits have been granted.

Cost relief can be considered on claims where the pre-existing disease, condition or disability arose from an earlier compensable injury or disease with the same employer, where the date of injury or disease, for the injury or disease on which relief is sought, is on or after July 1, 1998. The date of the disease, for the purpose of this paragraph, is the date that the first claim document is registered at the Board.

ii. Evaluation Process

Any impact of the pre-existing disease, condition or disability on the occurrence of the compensable *injury* is irrelevant to the question of whether cost relief will be granted for the enhanced *disability*.

Three questions are considered when evaluating the application of section 240(1)(d).

1. *Was there a pre-existing disease, condition or disability, and if so, to what extent?*

A "pre-existing" disease, condition or disability is one that exists before the compensable injury and is established by a confirmed diagnosis or medical opinion. It does not have to be symptomatic prior to the compensable incident, nor does there have to be previous medical treatment or disability related to the pre-existing disease, condition or disability, for it to be considered for the purposes of relief of costs under section 240(1)(d).

If a worker has a compensable personal injury (including mental disorder or occupational disease), and there is no evidence of any pre-existing disease, condition or disability, section 240(1)(d) does not apply. The fact that a disability has been enhanced by factors other than a pre-existing disease, condition or disability is not a ground for relief under section 240(1)(d).

2. *Was the worker's compensable disability enhanced by reason of a pre-existing disease, condition or disability, and if so, to what extent?*

"Enhanced" can mean either the prolongation of recovery or the extent to which the compensable disability is made worse, due to the pre-existing disease, condition or disability.

Evidence that may be considered in determining the degree of prolongation or worsening of a disability includes:

- medical opinion regarding the "normal" recovery time for the particular type of injury;
- medical opinion regarding the "normal" post-surgical recovery time;
- the requirement of additional health care services (physiotherapy, hospitalization, etc.); and
- medical evidence contained on the claim.

All relevant factors are considered in the decision-making process.

If the severity of the compensable accident, incident or exposure was relatively minor, but there is evidence that the recovery period was prolonged, or the temporary or permanent disability was made worse, by reason of a pre-existing disease, condition or disability, cost relief under section 240(1)(d) will clearly be applicable.

3. How severe was the incident initiating the claim in question?

If there is confirmation of a pre-existing disease, condition or disability of a minor degree, but the incident which precipitated the compensable claim was of a severe nature, cost relief under section 240(1)(d) will not normally be applicable.

Since section 240(1)(d) specifically refers to the enhancement of "disability", it has no application in fatal cases or in cases where only health care benefits are payable.

iii. Determining Amount of Cost Relief

After it has been determined that a pre-existing disease, condition or disability has enhanced the compensable disability, the Board then determines the amount of cost relief to be granted to an employer.

The grid below is one tool that may be used to determine the amount of cost relief to be granted to an employer. It plots the medical significance of the pre-existing disease, condition or disability against the severity of the accident, incident or exposure resulting in the compensable disability.

Medical Significance of Pre-existing Disease, Condition or Disability	Severity of Accident, Incident or Exposure	Percentage of Cost Relief
Minor	Minor	50%
	Moderate	25%
	Major	0%
Moderate	Minor	75%
	Moderate	50%
	Major	25%
Major	Minor	90-100%
	Moderate	75%
	Major	50%

Medical Significance

A determination of the medical significance of the pre-existing disease, condition or disability is based on a review of the medical evidence and, where applicable, an opinion from the Board.

Severity

The severity of the accident, incident or exposure is generally determined by a review of the factual evidence, including the mechanics of the injury, the activity the worker was undertaking at the time of the injury and the conditions of the worksite.

The following definitions will assist in assessing the severity of the accident, incident or exposure:

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

Percentage

How much disability stems from the compensable injury and how much from the enhancement of the disease, condition or disability and, therefore, to what extent costs should be charged under section 240(1)(d) can never be more than an estimate and will always be difficult to determine.

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

In cases of continuing wage-loss benefits and health care benefits, it may be appropriate for the Board to determine that after a particular point in time, all the costs are charged under section 240(1)(d). Alternatively, it may also be determined that a percentage is relieved from a certain time onwards.

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

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

In respect of permanent disability benefits, it is necessary for the Board to establish a percentage of cost relief to be granted based on the applicable medical evidence. It is noted that 100% cost relief cannot be granted for permanent disability benefits, as this would imply that no portion of the permanent disability resulted from the work-related injury.

iv. Timing of Cost Relief Decisions

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

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

b) the conclusion of temporary disability compensation; or

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

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

v. Communication of Cost Relief Decisions

The Board notifies the eligible employer of all section 240(1)(d) cost relief decisions.

If there is a disagreement with such a decision, the employer may request a review by the Review Division.

B. RELATIONSHIP BETWEEN SECTIONS 146 AND 240(1)(d)

It is important to distinguish between the provisions of section 146 and section 240(1)(d) of the *Act*, as discussed in Item C6-44.00 and policy in this Item. Section 146 deals with the situation where a disability resulting from a work injury is superimposed on a pre-existing disability in the same part of the body and increases that disability, or if entitlement to permanent disability benefits is being determined on a loss of earnings basis under section 196, and the disability is deemed to be partly the result of a disability in another part of the body. The application of section 146 may result in a reduction in the amount of compensation paid to the worker.

Section 240(1)(d), on the other hand, is concerned only with the rate group to which the costs of the claim are to be charged and cannot affect the entitlement of the worker. It can apply in cases where section 146 does not apply and the whole of the worker's disability results from the injury or, if section 146 does apply, to the portion of disability for which the Board is responsible. It provides relief for the rate group of the worker's employer if the disability or portion of disability accepted under the claim is worse because of a pre-existing disease, condition or disability than it otherwise would be. That condition might well be in a different part of the worker's body.

C. APPLICATION OF SECTION 240(1)(d) TO OCCUPATIONAL DISEASES

Section 240(1)(d) of the *Act* will not be applied to occupational disease claims simply because the disease results from exposure in several different employments. That situation is dealt with in Item C17-114.50. However, there may be cases where the disability caused by an occupational disease was enhanced by a pre-existing condition. Section 240(1)(d) can be applied in such cases if the criteria outlined in policy in this Item are met.

EFFECTIVE DATE: Section A is effective September 1, 2020.
Section B is effective March 1, 2005.

AUTHORITY: Section 240 of the *Act*.

CROSS REFERENCES: Item C12-97.30, *Medical Evidence*;
Item C17-114.00, *Experience Rating Cost Exclusions*;
Item C17-114.50, *Charging Costs of Occupational Disease and Hearing Loss Claims*, of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY: December 1, 2025 – This policy resulted from the consolidation of former policy items #114.40, #114.41, and #114.42, consequential to reformatting and renumbering policies in Chapter 17, *Charging of Claim Costs*.
January 1, 2021 – Housekeeping change made to cross-reference consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*.
September 1, 2020 – Policy amended to remove a spent provision.
April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
May 1, 2011 – Housekeeping amendments to remove references to specific job titles, departments, appellate bodies and update references to external government bodies.
April 8, 2005 – Housekeeping amendments.
March 1, 2005 – Combination and replacement of policy items #114.40A, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*, #114.40B, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*, #114.43, *Procedure Governing Applications under Section 39(1)(e)*, and #114.50, *Sections 39(1)(d), 39(1)(e) and Federal Government Claims*, of this *Manual*; incorporated policy previously set out in Panel of Administrators' Resolution No. 1998/04/23-03 *Re: Section 39(1)(e)*: section 240(1)(d) cost relief consideration does not occur on claims where wage loss ended and/or permanent disability compensation was established on or before December 31, 1993; on or after July 1, 1998, section 240(1)(d) cost relief consideration is available for claims in which the pre-existing disease, condition or disability arises from an earlier compensable injury or disease with the same employer as the compensable injury or disease for which relief is sought; incorporated portions of, and retired from policy status, *Workers' Compensation Reporter* Decision No. 271, [1971] 4 W.C.R. 10; further amendments clarified the evaluation process for allocating cost relief. Updated language, consistent with rate making system in *Assessment Manual*. This policy continues the substantive requirements as they existed prior to the effective date.

APPLICATION: Section A applies to all decisions made on or after September 1, 2020.
Section B applies to all decisions made on or after March 1, 2005.

RE: Charging Costs of Occupational Disease and Hearing Loss Claims **ITEM: C17-114.50**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on how costs of occupational disease claims, including silicosis and pneumoconiosis, and non-traumatic hearing loss claims are charged.

2. The Act

Section 250:

(1) If compensation is paid

(a) under section 141 *[mining industry silicosis]* in relation to a worker who was exposed to the inhalation of silica dust in 2 or more classes or subclasses of industry in British Columbia, or

(b) under section 142 *[lung disease from exposure to dust conditions]* in relation to a worker who was exposed to dust conditions in 2 or more classes or subclasses of industry in British Columbia,

the Board may apportion the cost of compensation among the funds provided by those classes or subclasses on the basis of the duration and severity of the exposure in each.

(2) If compensation is paid under section 145 *[non-traumatic hearing loss]* in relation to a worker's hearing loss caused by exposure to causes of hearing loss in 2 or more classes or subclasses of industry in British Columbia, the Board may apportion the cost of compensation among the funds provided by those classes or subclasses on the basis of the duration or severity of the exposure in each.

POLICY

A. OCCUPATIONAL DISEASES

The long period of exposure required for the development of some occupational diseases raises special problems in connection with the charging of claim costs. The position is the same as for injuries when the exposure has been with one employer only, but there are commonly situations where the relevant exposure has occurred during

employments with two or more employers. The general rules followed in these cases are as follows:

1. Until September 27, 2002, all wage-loss benefits and health care benefits were charged to the class of the employer at the time the claim was submitted for the first 13 weeks. Effective September 28, 2002, all wage-loss benefits and health care benefits are charged to the class of the employer at the time the claim was submitted for the first 10 weeks.

2. Until September 27, 2002, an assessment of the worker's work exposure history was then made and an apportionment of the costs incurred beyond 13 weeks, including the amount of any permanent disability reserve, was carried out. The class of the employer at the time the claim was submitted would be charged with the portion of costs incurred after the 13 weeks, which was attributable to the worker's employment with the employer, provided that that portion exceeded 20% of the total amount. The balance would not be charged to any particular class but would be spread across all classes of industry.

   Effective September 28, 2002, an assessment of the worker's work exposure history is then made and an apportionment of the costs incurred beyond 10 weeks, including the amount of any permanent disability reserve, is carried out. The class of the employer at the time the claim is submitted will be charged with the portion of costs incurred after the 10 weeks, which is attributable to the worker's employment with the employer, provided that that portion exceeds 20% of the total amount. The balance will not be charged to any particular class but will be spread across all classes of industry.

3. Until September 27, 2002, if any portion attributable to any employer at the time the claim was submitted was less than 20%, the costs incurred following 13 weeks were not charged to any employer's class, but would be spread across all classes of industry. To ensure procedural fairness in the event of a request for review or an appeal in cases where the class has changed, decision letters and review and appeal information were sent to the employers' association that best represented the appropriate class and subclass of industry.

   Effective September 28, 2002, if any portion attributable to any employer at the time the claim is submitted is less than 20%, the costs incurred following 10 weeks are not charged to any employer's class, but will be spread across all classes of industry. To ensure procedural fairness in the event of a request for review or an appeal in such situations, decision letters and review and appeal information are sent to the employers'

association that best represents the appropriate class and subclass of industry.

4. The apportionment is made by comparing the number of years of exposure with the employer at the time the claim is submitted with the worker's total exposure. No account is taken of varying degrees of exposure which may have occurred at different times.

B. SILICOSIS AND PNEUMOCONIOSIS

If, in the case of silicosis or pneumoconiosis claims, there is exposure to silica dust or other dust conditions in more than one subclass of industry within British Columbia, costs are normally apportioned on the basis of employment records confirming the exposure. Occasionally, it is difficult to be precise about exact periods of exposure because absolute confirmation of employment is not always available many years after the fact. This is because employers may no longer be in business or the worker is unable to provide a complete résumé of employment. Under the circumstances, there may be a few cases where it is unfair to simply use employment records for the charging of costs, particularly if there is other substantive evidence available to support exposure to silica dust in a certain class or classes of industry. The Board therefore has discretion in the apportionment of costs for silicosis or pneumoconiosis claims, where it appears that the sole use of employment records will produce an inequitable result.

The guidelines set out below are followed:

1. Cost for silicosis or pneumoconiosis claims will normally be apportioned on the basis of confirmed periods of employment in industries where there is exposure to silica dust or other dust conditions.

2. If confirmed employment records are unavailable, but there is other substantive evidence to support periods of exposure to silica dust or other dust conditions, the Board has discretion to apportion costs on the basis of the best evidence available.

3. If a worker is entitled to compensation for silicosis or pneumoconiosis under the terms of section 136, 137, 141, 142, or 143 of the *Act*, the costs will be charged to the appropriate class or classes of industry within British Columbia as provided by the *Act*.

C. HEARING-LOSS CLAIMS

The procedure followed to implement section 250(2) of the *Act* is set out below.

1. An assessment is made of the worker's work exposure history and an apportionment made as between the various employers concerned of the cost of compensation paid out. The apportionment is made by allocating

to each period of employment a factor varying in accordance with the loudness of the noise experienced and multiplying this by the number of years exposed in each employment. The resulting figures for each employment are totalled and the percentage attributable to each is calculated by reference to this total.

2. The costs of a claim are attributed to individual employers in accordance with their percentage where those percentages are 20% or greater. If the percentages of any employers are less than 20%, the equivalent percentages of the costs of the claim are not attributed to any particular employer, but are still charged to the appropriate class of industry.

3. If the total exposure in British Columbia is 5% or less, the claim is disallowed. If the total exposure in British Columbia is 90% or greater, the Board accepts responsibility for the whole hearing loss.

4. If there is only one employer, but (because of non-occupational or out-of-province exposure) responsibility is less than 20%, the full costs of the claim are nevertheless attributed to that employer.

EFFECTIVE DATE:	Section A is effective March 3, 2003. Section B is effective June 1, 2009.
AUTHORITY:	Section 250 of the *Act*.
CROSS REFERENCES:	Item C4-31.00, *Hearing Loss* (Section C. *Amount and Duration of Noise Exposure Required by Section 145*); Item C17-114.00, *Experience Rating Cost Exclusions*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #113.20, #113.21, and #113.22, consequential to reformatting and renumbering policies in Chapter 17, *Charging of Claim Costs*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. June 1, 2009 – Deleted references to Board officer. March 3, 2003 – Changes were made regarding references to review.
APPLICATION:	Section A applies to all decisions made on or after March 3, 2003. Section B applies on or after June 1, 2009.

RE: Injuries or Aggravations in the Course of Medical Treatment, Appointments and Related Travel **ITEM: C17-114.60**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on ER exclusions for certain claim costs related to injuries or aggravations in the course of medical treatment, appointments or related travel.

2. The Act

Section 247(2):

> If the Board considers that a particular industry or plant is circumstanced or conducted such that the hazard or cost of compensation differs from the average of the class or subclass to which the industry or plant is assigned, the Board
>
> (a) must establish a special rate, differential or assessment for that industry or plant to correspond with the relative hazard or cost of compensation of the industry or plant, and
>
> (b) for the purpose referred to in paragraph (a), may also adopt a system of experience rating.

POLICY

If there is an aggravation of an injury or a subsequent injury arising out of treatment, surgery, Board-related assessment, or travel for exceptional medical treatment or examination for the primary injury, and the aggravation or subsequent injury is acceptable on the claim, compensation costs resulting from this secondary problem will be charged in the usual way. Exclusion from the employer's ER will only occur if:

1. the original injury was one that would not have been expected to result in death or the permanent disability, or the increased disability, that occurred;

2. the aggravation or subsequent injury occurred beyond the operations of the employer, and if the worker required transportation to a hospital or other place of medical treatment, after the employer had fulfilled the obligations under section 159 of the *Act* (see Item C10-83.30); and

3. the aggravation or subsequent injury resulted in permanent disability or death.

The application of relief is limited to the permanent disability compensation reserve established for a fatality or the permanent disability, or portion of the permanent disability, that resulted from the aggravation or subsequent injury arising out of treatment, surgery, Board-related assessment, or travel for exceptional treatment or examination.

Consideration is automatically given by the Board to excluding the costs from ER in these cases. No request from the employer is required. The employer will be advised of the decision in writing and of the relevant review and/or appeal rights.

EFFECTIVE DATE:	January 1, 2016
AUTHORITY:	Section 247 of the *Act.*
CROSS REFERENCES:	Item C3-22.00, *Compensable Consequences*; Item C3-22.10, *Compensable Consequences – Travel* (esp. for meaning of travel for exceptional treatment or examination); Item C10-83.30, *Date of Injury Transportation*; Item C17-114.00, *Experience Rating Cost Exclusions*; Item C17-114.70, *Certain Compensable Consequences*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from former policy item #115.31, consequential to reformatting and renumbering policies in Chapter 17, *Charging of Claim Costs*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. January 1, 2016 – Policy amended to clarify that the costs of injuries or aggravations arising out of surgery, Board-related assessment, and travel for exceptional medical treatment or examination will be excluded from an employer's experience rating per injuries or aggravations arising out of treatment. January 1, 2015 – Consequential amendments were made effective, arising from changes to then Chapter 10, *Medical Assistance,* of the *Rehabilitation Services & Claims Manual*, Volume II. June 1, 2009 – Policy updated to reflect the wording of decision-makers, departments, appellate bodies, and external agencies. March 3, 2003 – Amended to delete references to the Review Board and the Appeal Division. June 30, 2002 – Housekeeping changes were made to update terminology.
APPLICATION:	Applies to all decisions made on or after January 1, 2016.

RE: Certain Compensable Consequences **ITEM: C17-114.70**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on ER exclusions for certain claim costs related to certain compensable consequences.

2. The Act

Section 247(2):

> If the Board considers that a particular industry or plant is circumstanced or conducted such that the hazard or cost of compensation differs from the average of the class or subclass to which the industry or plant is assigned, the Board
>
> (a) must establish a special rate, differential or assessment for that industry or plant to correspond with the relative hazard or cost of compensation of the industry or plant, and
>
> (b) for the purpose referred to in paragraph (a), may also adopt a system of experience rating.

POLICY

A. AT PLACES OF TREATMENT, SURGERY, BOARD-RELATED APPOINTMENT, AND VOCATIONAL REHABILITATION

The Board considers places of treatment, surgery, appointment (including pre-arranged appointments at the Board or Workers' Compensation Appeal Tribunal), or Vocational Rehabilitation that a worker attends because of a compensable injury analogous to the worker's place of employment.

A further injury, increased disablement, disease, or death arising at such a location may therefore be compensable, if the Board has determined that the parameters set out in Item C3-22.00 were met. This includes a further injury sustained by a worker stumbling down the stairs at the location in question while en route to the pre-arranged appointment.

The Board includes most costs of the compensable consequences that occur at the place of treatment, surgery, and pre-arranged appointment (including appointments at

the Board or Workers' Compensation Appeal Tribunal) when calculating an employer's ER.

There are two exceptions. One is for compensable consequences that occur at the location in question, but which are not a direct consequence of the treatment, surgery, or Board-related assessment itself, or actually caused by the condition resulting from the compensable injury. The Board normally excludes the costs of these compensable consequences from the employer's ER.

The second exception is for the compensable consequences of Vocational Rehabilitation. With respect to Board-approved Vocational Rehabilitation plans, the Board normally excludes the following costs from the participating employer's ER:

- the costs arising from injuries or aggravations that occur during the course of Board-sponsored work assessments described in Item C11-88.10;
- the costs of certain employment injuries and aggravations occurring in the course of training-on-the-job programs described in Item C11-88.40; and
- the costs of an aggravation or new injury to a trainee participating in a Vocational Rehabilitation Formal Training program described in Item C11-88.50.

B. TRAVEL TO PLACES OF TREATMENT, SURGERY, APPOINTMENT, AND VOCATIONAL REHABILITATION

As set out in Section A of Item C3-22.10, the Board considers travel to and from places of treatment, surgery, appointment, and Vocational Rehabilitation analogous to the worker's regular commute to and from work. For this reason, further injuries, increased disablement, or death sustained in the course of this travel are not generally compensable and cost allocation is not an issue.

However, the Board may have determined that a further injury, increased disablement, or death sustained in the course of such travel was a compensable consequence of the compensable injury, if the parameters set out in Section B of Item C3-22.10 were met. This includes traveling to pre-arranged appointments at the Board or Workers' Compensation Appeal Tribunal.

So long as the condition resulting from the compensable injury did not actually cause the accepted compensable consequence, the Board normally excludes the costs of the compensable consequences that occur in the course of travel to and from places of treatment, surgery, and pre-arranged appointment (including appointments at the Board or Workers' Compensation Appeal Tribunal) from the employer's ER.

C. EXCLUDING THE COSTS FOR FURTHER TEMPORARY DISABILITY

In order to exclude the costs of one of the exceptional compensable consequences discussed above from an employer's ER, the Board estimates when the worker would have recovered or stabilized from the original compensable injury.

When the Board's estimated date for recovery arrives, the Board excludes the claim costs beyond that date from the employer's ER if:

- the worker is still temporarily disabled; and
- there is no clear evidence that the continuing temporary disability is due to the original compensable injury.

D. EXCLUDING THE COSTS FOR FURTHER PERMANENT DISABILITY

The Board may exclude the costs of one of the exceptional compensable consequences discussed above from an employer's ER for permanent disability or fatality compensation under policy in Item C17-114.60.

EFFECTIVE DATE:	January 1, 2016
AUTHORITY:	Section 247 of the *Act*.
CROSS REFERENCES:	Item C3-22.00, *Compensable Consequences*; Item C3-22.10, *Compensable Consequences – Travel*; Item C11-88.10, *Vocational Rehabilitation – Work Assessments*; Item C11-88.40, *Vocational Rehabilitation – Training-on-the-Job*; Item C11.88.50, *Vocational Rehabilitation – Formal Training*; Item C17-114.00, *Experience Rating Cost Exclusions*; Item C17-114.60, *Injuries or Aggravations in the Course of Medical Treatment, Appointments and Related Travel*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from former policy item #115.34, consequential to reformatting and renumbering policies in Chapter 17, *Charging of Claim Costs*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. This new policy was approved and brought into effect by BOD Resolution No. 2015/05/27-03.
APPLICATION:	Applies to all claims for injuries that occur on or after January 1, 2016.

RE: Subsequent Non-Compensable Incidents **ITEM: C17-114.80**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on ER exclusions for certain claim costs related to subsequent non-compensable incidents, and provides these costs are also not charged to the employer's rate group.

2. The Act

Section 247(2):

> If the Board considers that a particular industry or plant is circumstanced or conducted such that the hazard or cost of compensation differs from the average of the class or subclass to which the industry or plant is assigned, the Board
>
> (a) must establish a special rate, differential or assessment for that industry or plant to correspond with the relative hazard or cost of compensation of the industry or plant, and
>
> (b) for the purpose referred to in paragraph (a), may also adopt a system of experience rating.

POLICY

A worker may continue to receive temporary disability wage-loss benefits where recovery from a compensable disability is delayed due to a subsequent non-compensable incident.

As set out in Section 3.6 of the policy in Item C5-34.00, the Board estimates when the worker would have reached maximum medical recovery. The Board continues to pay wage-loss benefits for the period that the Board estimates the worker would have taken to reach maximum medical recovery from the compensable injury had the subsequent non-compensable incident not occurred.

When the estimated date for terminating wage-loss benefits arrives, if the worker is still disabled, the Board makes a new decision as to whether the disability is due to the compensable injury, mental disorder, or occupational disease, or the subsequent non-compensable incident. If the disability is due to the compensable injury, mental disorder, or occupational disease, wage-loss benefits may be continued.

If the delay in recovery is due to the subsequent non-compensable incident, the cost of compensation associated with the delay in recovery beyond the estimated date for terminating temporary disability wage-loss benefits is excluded from the employer's ER. These costs will also not be charged to the employer's rate group, but will be spread across all rate groups.

Claims costs associated with permanent disability benefits would not be relieved under this policy.

EFFECTIVE DATE:	August 1, 2010
AUTHORITY:	Section 247 of the *Act*.
CROSS REFERENCES:	Item C5-34.00, *Duration of Wage-Loss Benefits* (Section 3.6, Subsequent Non-Compensable Incidents); Item C17-114.00, *Experience Rating Cost Exclusions*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from former policy item #115.33, consequential to reformatting and renumbering policies in Chapter 17, *Charging of Claim Costs*. January 1, 2024 – Housekeeping changes to reflect language updates to Chapter 5, *Wage-Loss Benefits and Return to Work Obligations*, and to update internal cross reference. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
APPLICATION:	Applies to all decisions made on or after August 1, 2010.

RE: Claims Involving a Permanent Disability and a Fatality **ITEM: C17-114.90**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on ER exclusions for certain costs related to claims involving a fatality.

2. The Act

Section 247(2):

> If the Board considers that a particular industry or plant is circumstanced or conducted such that the hazard or cost of compensation differs from the average of the class or subclass to which the industry or plant is assigned, the Board
>
> (a) must establish a special rate, differential or assessment for that industry or plant to correspond with the relative hazard or cost of compensation of the industry or plant, and
>
> (b) for the purpose referred to in paragraph (a), may also adopt a system of experience rating.

POLICY

ER does not include the actual cost of the fatal claims experienced by an employer. Rather, it includes for each claim the average cost for all fatal claims in the year. A worker in receipt of permanent disability benefits may die as a result of the injury or disease accepted under the claim. If compensation is payable to dependants, the cost otherwise included in ER may be reduced to the extent set out below:

1. Where the average cost of compensation for a fatality is the same or less than that of the permanent disability benefits, the total cost of the compensation for the fatality is excluded.

2. Where the average cost of compensation for a fatality is greater than that of the permanent disability benefits, a portion of the cost of the compensation for the fatality equal to the reserve charged to the employer for the permanent disability benefits is excluded.

AUTHORITY:	Section 247 of the *Act*.
CROSS REFERENCES:	Item C17-114.00, *Experience Rating Cost Exclusions*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – This policy resulted from former policy item #115.32, consequential to reformatting and renumbering policies in Chapter 17, *Charging of Claim Costs*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

RE: Interjurisdictional Agreements **ITEM: C17-115.10**

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the interjurisdictional agreement between the Board and other provinces and territories of Canada, including its provisions on charging of claim costs.

2. The Act

Section 335:

(1) The Board may enter into agreements or make arrangements with Canada, a province or a territory, or with the appropriate authority of Canada, a province or a territory, respecting the following:

(a) administrative cooperation and assistance between jurisdictions in all matters under this Act and corresponding legislation in other jurisdictions;

(b) the provision of compensation, rehabilitation and health care to workers in accordance with the standards established under this Act or corresponding legislation in other jurisdictions;

(c) avoidance of duplication of assessments on workers' earnings.

(2) An agreement or arrangement under this section may

(a) waive or modify a residence or exposure requirement for eligibility for compensation, rehabilitation or health care, or

(b) provide for payment to an appropriate authority of Canada or an appropriate authority of a province or a territory for compensation, rehabilitation costs or health care costs paid by the authority.

POLICY

The Board has entered into the Interjurisdictional Agreement on Workers' Compensation with the other provinces and territories of Canada, which contains provisions to deal with situations where an injury, or exposure to the causes of an

occupational disease occurs in another province or territory. In addition, it contains a system to permit the Board to help another Board's workers or dependants and a method of resolving disputes between Boards.

An employer who carries on business in British Columbia may be required to register with this Board as an employer even though carrying on business and registering as an employer with the Board in another province or territory.

If a worker of such an employer incurs an injury or occupational disease and is eligible to claim compensation in this and another province or territory, the employer's class will be charged with the costs of the claim subject to adjustment resulting from any reimbursements received or made under the terms of the Interjurisdictional Agreement.

AUTHORITY:	Section 335 of the *Act*.
CROSS REFERENCES:	Item AP5-245-3, *Payroll – Out-Of-Province Employers and Operations*, of the *Assessment Manual*.
HISTORY:	December 1, 2025 – This policy resulted from former policy item #113.30, consequential to reformatting and renumbering policies in Chapter 17, *Charging of Claim Costs*. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.

RE: Provisions Charging Individual Employers **ITEM: C17-115.20**

BACKGROUND

1. Explanatory Notes

This policy sets out when claim costs may be charged to the individual employer, instead of the employer's rate group, in situations where an employer does not meet its obligations in reporting an injury, disabling occupational disease or death and in situations where an employer fails to register or provide payroll estimates and reports.

2. The Act

Section 150, in part:

(1) Subject to subsection (7), an employer must report to the Board, within 3 days after its occurrence, every injury to a worker that is or is claimed to be an injury arising out of and in the course of the worker's employment.

(2) Subject to subsection (7), an employer must report to the Board, within 3 days after receiving information under section 149, every disabling occupational disease or claim for or allegation of an occupational disease in relation to a worker.

(3) An employer must report immediately to the Board the death of a worker if the death is or is claimed to be a death arising out of and in the course of the worker's employment.

…

(8) If a report required under this section is not received by the Board within 7 days after an injury or death, or any other time prescribed by regulation under subsection (7), the Board

(a) may make an interim adjudication of the claim, and

(b) if the Board allows the claim on an interim basis, may begin the payment of compensation in whole or in part.

Section 245(1):

An employer must do the following:

(a) keep at all times at a place in British Columbia complete and accurate particulars of the employer's payrolls;

(b) notify the Board of the current location of the place referred to in paragraph (a);

(c) provide to the Board an estimate of the probable amount of the payroll of each of the employer's industries within the scope of the compensation provisions, together with any further information required by the Board,

(i) when the employer becomes an employer within the scope of those provisions, and

(ii) at other times as required by Board regulation of general application or by an order of the Board limited to a specific employer;

(d) provide to the Board certified copies of reports of the employer's payrolls, on or after the end of each calendar year and at the other times and in the manner required by the Board.

Section 262:

(1) This section applies if the Board pays compensation under section 150(8) *[payment of compensation where employer defaults in reporting]*.

(2) If compensation is paid under section 150(8) before 3 days after the Board receives the report required by that section, that compensation may be levied and collected from the employer by way of additional assessment as a contribution to the accident fund, and payment may be enforced in the same manner as other assessments.

(3) If 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 this section.

Section 263:

(1) This section applies if an employer

(a) refuses or neglects to make or provide a payroll estimate or other record required to be provided by the employer under section 245(1) *[employer obligation to provide payroll estimates and reports]*, or

(b) refuses or neglects to pay

(i) an assessment,

(ii) the provisional amount of an assessment, or

(iii) an instalment or part of an assessment or a provisional amount of an assessment.

(2) Subject to subsection (4), the employer must, in addition to any penalty or other liability to which the employer may be subject, pay the Board the full amount or capitalized value, as determined by the Board, of the compensation payable in respect of an injury or occupational disease to a worker in the employer's employ that happens during the period of the default referred to in subsection (1).

(3) The payment of an amount required to be paid under subsection (2) may be enforced in the same manner as the payment of an assessment may be enforced.

(4) If satisfied that the default was excusable, the Board may in a specific case relieve the employer in whole or in part from liability under this section.

POLICY

A. PROVISIONS CHARGING INDIVIDUAL EMPLOYERS

One provision regarding charging individual employers is discussed in Item C12-94.10. Section 262 of the *Act* permits the Board to charge an employer with the costs of a claim where late in submitting a report of injury to the Board.

Another provision of this nature is discussed below.

B. FAILURE TO REGISTER AS AN EMPLOYER AT THE TIME OF INJURY

If an employer is an employer to which the *Act* extends compulsory coverage, failure to register with the Board as an employer will not prejudice any claim by the employees unless the provisions set out in the policy in Item AP1-1-1 of the *Assessment Manual* apply. However, the employer may be faced with paying the costs of the claim under section 263 of the *Act*, which provides, in part:

> (1) This section applies if an employer
>
> (a) refuses or neglects to make or provide a payroll estimate or other record required to be provided by the employer under section 245(1) *[employer obligation to provide payroll estimates and reports]*, or
>
> (b) refuses or neglects to pay
>
> (i) an assessment,
>
> (ii) the provisional amount of an assessment, or
>
> (iii) an instalment or part of an assessment or a provisional amount of an assessment.
>
> (2) Subject to subsection (4), the employer must, in addition to any penalty or other liability to which the employer may be subject, pay the Board the full amount or capitalized value, as determined by the Board, of the compensation payable in respect of an injury or occupational disease to a worker in the employer's employ that happens during the period of the default referred to in subsection (1).
>
> (3) The payment of an amount required to be paid under subsection (2) may be enforced in the same manner as the payment of an assessment may be enforced.
>
> ...

Under section 263(4), if satisfied that the default was excusable, the Board may in a specific case relieve the employer in whole or in part from liability under section 263.

The Board has decided that section 263 applies to claims for fatalities.

The charge made under section 263 is in addition to any ordinary assessments which the employer may be liable to pay for the period prior to the occurrence of the injury.

Item C17-115.10 dealt with the rules followed in charging the costs of claims where an employer is carrying on business in two or more provinces and is required to register in both. If such an employer is not registered in British Columbia at the time of an injury, there may be personal liability for the costs of the claim under section 263 in any situation where, under the provisions of the Interjurisdictional Agreement or otherwise, the employer's class would ordinarily be charged.

EFFECTIVE DATE:	Section B is effective January 1, 2023.
AUTHORITY:	Sections 150, 245, 262, and 263 of the *Act*.
CROSS REFERENCES:	Item C12-94.10, *Employer Penalties for Failure to Report*; Item C17-114.00, *Experience Rating Cost Exclusions*; Item C17-115.10, *Interjurisdictional Agreements*, of the *Rehabilitation Services & Claims Manual*, Volume II. Item AP1-1-1, *Coverage under Act – Determining Workplace Status*, of the *Assessment Manual*.
HISTORY:	December 1, 2025 – This policy resulted from the consolidation of former policy items #115.00 and #115.10, consequential to reformatting and renumbering policies in Chapter 17, *Charging of Claim Costs*. January 1, 2023 – Consequential changes related to the consolidation of policies on determining workplace status were made effective. April 6, 2020 – Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. March 18, 2003 – Changes were made regarding numerical reference to the policy in Item AP1-1-4 of the *Assessment Manual*.
APPLICATION:	Section B applies to all decisions made on or after January 1, 2023.

RE:	Retirement Benefits − Establishment of Amounts Set Aside and Contributed	ITEM:	C18-116.00

BACKGROUND

1. Explanatory Notes

The *Workers Compensation Act*, R.S.B.C. 1996, c. 492, as amended by the *Amendment Act, 2002*, established the provision of a retirement benefit for an injured worker in receipt of permanent disability periodic payments. The retirement benefit is intended to compensate a worker for the impact of the worker's permanent disability on the worker's ability to accumulate retirement savings.

Under section 204 of the *Act*, the Board sets aside an amount toward the establishment of a retirement benefit. A worker may also apply to the Board under section 205 to contribute a portion of the worker's permanent disability periodic payments in addition to the amounts set aside by the Board.

2. The Act

Section 120:

(1) The following apply to an amount payable as compensation or by way of commutation of a periodic payment in respect of compensation:

(a) the amount is not capable of being assigned, charged or attached;

(b) the amount must not pass by operation of law except to a personal representative.

(2) A claim must not be set off against an amount referred to in subsection (1), except for money

(a) advanced by way of financial or other social welfare assistance owing to the government, or

(b) owing to the accident fund.

Section 190:

Compensation under this Division [Division 6 of Part 4 of the *Act* − Compensation for Worker Disability] is subject to the following provisions:

(a) section 230 *[manner of compensation payment: periodic or lump sum]*;

(b) section 231 *[payment of compensation in specific circumstances]*;

(c) section 232 *[Board authority to discontinue or suspend payments]*;

(d) section 233 *[deduction in relation to payments from employer]*.

Section 202:

(1) This section applies to a worker who receives

(a) a periodic payment of compensation under section 194(1), 195(1) or 196(1) *[compensation for permanent disability]* in respect of an injury, and

(b) a disability benefit under the *Canada Pension Plan* in respect of the injury.

(2) Subject to sections 194(2), 195(2) and 198(5) *[minimum compensation payments]*, the Board must deduct from a periodic payment referred to in subsection (1)(a), an amount that equals 50% of any disability benefit paid as referred to in subsection (1)(b).

Section 204:

(1) This section applies to a worker who is receiving periodic payments under section 194(1), 195(1) or 196(3) *[compensation for permanent disability]*.

(2) The Board must set aside, at the time a periodic payment is made to a worker, an amount that

(a) equals 5% of the periodic payment, and

(b) is in addition to the periodic payment.

(3) The Board must provide each worker with an annual statement containing all relevant information about the funds accumulated by the Board for payment of the worker's retirement benefit.

Section 205:

(1) A worker may apply to the Board to contribute to the amount set aside or to be set aside under section 204 an amount that is not less than 1% and

not greater than 5% of each subsequent periodic payment made to the worker.

(2) Subject to subsection (3), if a worker makes an application under this section, the Board must, as soon as practicable, deduct the amount of the worker's contribution from each subsequent periodic payment made to the worker and add this contribution to the amount set aside under section 204.

(3) The deductions made by the Board under subsection (2) may not be varied, except in response to an application by the worker to stop the deductions.

(4) A worker may

(a) only once make an application for deductions under subsection (2), and

(b) only once make an application to stop the deductions under subsection (3).

(5) An application made under this section must be in a form acceptable to the Board.

POLICY

1. Amounts Set Aside by the Board

A worker who is in receipt of permanent total or permanent partial disability periodic payments is entitled to have an amount set aside by the Board toward the worker's retirement benefit.

Commencing on the effective date of permanent disability benefits, the Board will set aside an amount equal to 5% of a worker's permanent disability periodic payment. This amount is in addition to the permanent disability periodic payment. As well, the amount set aside is based on the worker's permanent disability periodic payment prior to any deductions for *Canada Pension Plan* disability benefits paid to the worker and any deductions made in accordance with section 120 of the *Act*.

The amounts set aside by the Board are deposited in a reserve in the Accident Fund.

However, if a worker's permanent disability benefits are totally or partially commuted, the future amounts to be set aside by the Board will also be totally or partially commuted. Please refer to Item C6-45.00 in Chapter 6, Permanent Disability Benefits

for additional information regarding the commutation of the future amounts to be set aside by the Board.

2. Voluntary Contributions

A worker may also contribute a portion of the worker's permanent disability periodic payments to the amount set aside by the Board.

As part of the notification of a worker's entitlement to permanent disability benefits, the Board will provide a worker with an application for voluntary contributions. A worker who wishes to contribute to the amount set aside by the Board is required to complete the application form indicating an amount that is not less than 1% and not greater than 5% of each subsequent permanent disability periodic payment made to the worker. The worker is required to return the completed application form to the Board.

Following receipt of a worker's application to contribute to the amount set aside by the Board, the Board will, as soon as practicable, deduct the indicated contribution amount from each subsequent periodic payment provided to the worker. The amount deducted is based on the worker's permanent disability periodic payment prior to any deductions for *Canada Pension Plan* disability benefits paid to the worker and any deductions made in accordance with section 120 of the *Act*.

The worker's contribution, along with the amounts set aside by the Board, are deposited in a reserve in the Accident Fund.

A worker's contribution amount may not be altered once started, except to cancel the contributions. A worker may only once make an application to the Board to stop the voluntary deductions. A request to stop the deductions must be provided to the Board on a Board prescribed application form. The Board will stop the deductions effective the month following receipt of the application by the Board.

In addition, a worker's decision to stop voluntary contributions is final and cannot later be reversed.

3. Retroactive Permanent Disability Benefits

Subject to section 190, permanent disability benefits under sections 194, 195 and 196 of the *Act* may be granted retroactively to a worker. The Board will set aside an amount equivalent to 5% of the retroactive permanent disability benefit in a reserve in the Accident Fund.

If a worker has chosen to make voluntary contributions toward a retirement benefit, the Board will also deduct from the retroactive permanent disability benefit an amount equal to the worker's voluntary contributions. This amount will be set aside in a reserve in the Accident Fund.

Interest on the retroactive amounts will only be granted in accordance with Item C7-50.00.

4. Annual Statement

Under section 204(3), the Board is required to provide a worker with an annual statement containing all relevant information about the amounts set aside by the Board for payment of the worker's retirement benefit. The Board will determine the types of information provided on the annual statement. The statement will include information regarding the status of the amounts set aside, any amounts contributed and any accumulated investment income.

5. Assignment or Attachment of Amounts Set Aside and Contributed

The amounts set aside by the Board and the worker's voluntary contributions are not subject to assignments, charges or attachments while these amounts are maintained in the retirement reserve. The retirement benefit is, however, subject to assignments, charges or attachments as set out in section 120 and Item C7-48.00 only when the retirement benefit is payable.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	Sections 204 and 205 of the *Act*.
CROSS REFERENCES:	Chapter 6, *Permanent Disability Benefits*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	December 1, 2025 – Housekeeping change to update internal cross-references, consequential to reformatting and renumbering Chapter 7, *Protection of and Deductions from Benefits*. April 3, 2023 − Housekeeping amendment. January 1, 2021 − Housekeeping change made to cross-reference consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. Prior to June 30, 2002, permanent total disability compensation (section 194) and permanent partial disability compensation assessed under the loss of function method of permanent disability assessment (section 195) were payable for the lifetime of the worker. The duration of permanent partial disability compensation assessed under the projected loss of earnings method (section 196) was addressed in then policy item #40.20, Duration of Projected Loss of Earnings Pensions.
APPLICATION:	This policy applies to injuries occurring on or after June 30, 2002 and to a worker whose permanent disability first occurs on or after June 30, 2002. This policy also applies to recurrences occurring on or after June 30, 2002.

RE:	Retirement Benefits – Payment of Retirement Benefits	ITEM:	C18-116.10

BACKGROUND

1. Explanatory Notes

The *Act* defines "retirement benefit" as a lump sum payable under section 206.

This section stipulates the amount that a worker will receive as a retirement benefit following the conclusion of permanent disability periodic payments. The benefit will be provided when the worker reaches age 65, or on the date of the worker's last monthly periodic payment, if after age 65.

Section 206 provides direction on the provision of the amounts set aside, and any contributions and accumulated investment income, to the worker's designated beneficiary, or estate, if a worker dies before the retirement benefit is paid.

2. The Act

Section 1, in part:

> **"retirement benefit"**, in relation to a worker, means the lump sum payable to the worker under section 206 *[payment of retirement benefit]*;
>
> ...

Section 206:

> (1) Subject to subsection (3), on the date determined under subsection (2), a worker is entitled to receive a lump sum that equals the total of
>
> (a) the amounts set aside for payment to the worker under section 204,
>
> (b) the contributions, if any, made by the worker under section 205, and
>
> (c) the accumulated investment income earned on those amounts and contributions.

(2) A worker's entitlement under subsection (1) is effective,

(a) subject to paragraph (b) of this subsection, on the date the worker reaches 65 years of age, or

(b) if the date of the last periodic payment to the worker is after the date the worker reaches 65 years of age, on the date of that last periodic payment.

(3) Despite section 231(4) *[Board discretion respecting amount accrued to worker]*, if a worker dies before receiving the worker's retirement benefit under subsection (1) of this section, the Board must, on the death of the worker, pay the lump sum to which the worker would have been entitled under that subsection to

(a) a beneficiary designated by the worker, or

(b) the worker's estate, if a beneficiary is not designated.

Subsection 230(2)(a):

(2) The Board may, at the Board's discretion, do the following:

(a) commute all or part of

(i) the periodic payments due or payable to a worker or dependant, and

(ii) the future amounts that are to be set aside for payment of a retirement benefit,

to one or more lump sum payments, to be applied as directed by the Board;

POLICY

1. Effective Date of Entitlement to a Retirement Benefit

The effective date of the retirement benefit will either be:

- the date the worker reaches 65 years of age; or
- the date of the last periodic payment to the worker, if that date is after the date the worker reaches 65 years of age, as determined by the Board.

2. Payment of Retirement Benefit

On the effective date of entitlement to a retirement benefit, a lump sum is provided to the worker equal to the following:

- the amounts set aside by the Board;
- the contributions, if any, made by the worker; and
- any accumulated investment income earned on those amounts and contributions.

A worker is guaranteed to receive the amounts set aside by the Board and any amounts the worker has contributed.

It is anticipated that investment income will be earned on the accumulated amount set aside by the Board and, if applicable, amounts contributed by the worker. However, in those cases where the accumulated investment return on the retirement reserve is negative, the loss will not be passed onto the worker.

3. Commutation of the Amounts Set Aside by the Board

If a worker is eligible for a commutation of the worker's permanent disability periodic payment, the *Act* provides that the future amounts to be set aside by the Board for payment of a retirement benefit will also be commuted.

Item C6-45.00 in Chapter 6, Permanent Disability Benefits, which is used to determine a worker's eligibility for commutation of permanent disability benefits, is also applied in the commutation of the amounts set aside by the Board.

4. Dormant Account

If the Board, at the time the retirement benefit is to be paid out as a lump sum, has no current address for a worker, and is otherwise unable to contact a worker, the reserve in the Accident Fund for the amounts set aside by the Board and the worker's contributions will be considered dormant. No further amounts will be set aside by the Board or contributed following the effective date of the retirement benefit.

5. Worker Dies Prior to Payment of Retirement Benefit

Upon the worker receiving notice from the Board of entitlement to have amounts set aside and contributed, the Board will request that the worker provide the name of the worker's designated beneficiary. A designated beneficiary is any person whom a worker designates to receive the funds deposited in the retirement reserve if the worker dies prior to receiving the retirement benefit. The Board will change the designated beneficiary, only following the receipt of a worker's written authorization.

If a worker dies prior to the payment of the retirement benefit, the Board will pay a lump sum to the designated beneficiary equal to the total of the amounts set aside by the Board, any voluntary contributions made by a worker, and any accumulated investment income earned on the amounts set aside and the contributions.

The designated beneficiary is guaranteed to receive at least the amounts set aside by the Board and any amounts the worker has contributed, and any accumulated investment income.

If a worker fails to designate a beneficiary, the lump sum outlined above will be paid to a worker's estate if the worker dies prior to receiving the retirement benefit.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	Section 206 of the *Act*.
CROSS REFERENCES:	Item C6-45.00, *Lump Sums and Commutations*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	January 1, 2021 – Housekeeping changes made to cross-references consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*. October 21, 2020 – Housekeeping amendments to the *Act* portion of the Background section to reflect amendments to the *Act* by the *Workers Compensation Amendment Act*, *2020* (Bill 23 of 2020), in effect August 14, 2020. April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
APPLICATION:	This policy applies to injuries occurring on or after June 30, 2002 and to a worker whose permanent disability first occurs on or after June 30, 2002. This policy also applies to recurrences occurring on or after June 30, 2002.

RE:	Retirement Benefits – Management of Funds Set Aside And Contributed	ITEM:	C18-116.20

BACKGROUND

1. Explanatory Notes

Section 207 specifies how the Board will manage the funds that are set aside for payment of a retirement benefit.

A reserve has been created under subsection 240(1)(f) to enable the Board to assess employers to cover the cost of the retirement benefit.

Section 327 of the *Act*, which provides direction regarding the investment and reinvestment of funds by the Board, will also apply to the amounts accumulated for retirement benefits.

2. The Act

Section 207:

(1) The Board must establish a reserve in the accident fund into which the amounts and contributions referred to in sections 204 and 205 must be deposited.

(2) The funds deposited in the reserve under subsection (1) must be held and invested in the name of the reserve, and those investments must clearly indicate that they are held in that reserve for payment of retirement benefits under section 206.

(3) If approved by the board of directors and on terms set by the Board, the Board may authorize a financial institution, as defined in the *Financial Institutions Act*, or a bank to administer the reserve referred to in subsection (1), and a financial institution or bank that is so authorized must comply with the relevant compensation provisions as if the financial institution or bank were the Board.

Subsection 240(1)(f):

> (1) For the purpose of assessment under section 241, the Board must every year make an estimate of sufficient funds to do the following:
>
> …
>
> (f) provide and maintain a reserve for payment of retirement benefits.

Section 327(2):

> Subject to the supervision and direction of the Minister of Finance, the Board must cause all money in the accident fund in excess of current requirements to be invested and reinvested and, in doing this, must exercise the care, skill, diligence and judgment that a prudent investor would exercise in making investments.

POLICY

Please refer to the Board's investment policies.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	Sections 207, 240(1)(f), and 327(2) of the *Act*.
CROSS REFERENCES:	Finance Division investment policy.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
APPLICATION:	This policy applies to injuries occurring on or after June 30, 2002 and to a worker whose permanent disability first occurs on or after June 30, 2002. This policy also applies to recurrences occurring on or after June 30, 2002.

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RE:	Retirement Benefits − Retirement Services and Personal Supports	ITEM:	C18-116.30

BACKGROUND

1. Explanatory Notes

Section 162 of the *Act* requires that the Board assess a worker, whose permanent total disability will continue past retirement age, for rehabilitation, health care services and personal supports. Following this assessment, the Board will then provide, or continue to provide, any required services and personal supports that a permanently totally disabled worker will need for the worker's lifetime.

This provision ensures that a permanently totally disabled worker will continue to receive the services and supports required because of the worker's disabilities, in addition to a retirement benefit.

2. The Act

Section 162:

(1) If a worker has a permanent total disability, the Board must, within the 3-month period before a retirement benefit under section 206 *[retirement benefits for workers with permanent disability]* is payable to the worker, evaluate the worker's need or continued need for services and personal supports under this Division [Division 4 of Part 4 of the *Act* − Vocational Rehabilitation, Health Care and Other Assistance].

(2) After the evaluation under subsection (1) is completed, the Board must take all actions necessary to provide to the worker, for the worker's life, the services and personal supports under this Division that the Board considers necessary.

(3) This section does not limit the power of the Board to otherwise provide services and personal supports to workers at any time under this Division.

POLICY

Within the 3-month period before a retirement benefit is payable to a worker, the Board will assess a worker who is receiving a permanent total disability periodic payment

under section 194 of the *Act*, for rehabilitation services, health care benefits and personal supports past retirement age.

This assessment is required to ensure that a worker has been considered for these services and personal supports prior to the conclusion of permanent total disability periodic payments and the granting of a retirement benefit. The services and supports considered are those that are normally provided to a worker as a result of a permanent total disability.

1. Rehabilitation Services, Health Care Services and Personal Supports

In assessing a worker, the Board will focus on those rehabilitation services, health care services and personal supports that a worker will need or continue to need after retirement. Types of services and supports include:

- physicians and qualified practitioners services (Item C10-76.00);
- health care rendered by other recognized health care professionals (Item C10-77.00);
- health care facilities (Item C10-78.00);
- health care supplies and equipment, including prescription medication (Item C10-79.00), and potentially addictive drugs (Item C10-80.00);
- home and vehicle modifications (Item C10-81.00);
- clothing allowances (Item C10-82.00);
- personal care expenses and allowances (Section 4.1 of Item C10-84.00);
- independence and home maintenance allowances (Section 4.5 of Item C10-84.00);
- transportation costs (Item C10-83.00);
- subsistence allowances (Item C10-83.10); or
- rehabilitation assistance (Chapter 11).

The services, benefits and supports listed above may be provided after age 65 if they are required due to the worker's permanent total disability.

2. Excluded Rehabilitation Services, Health Care Benefits and Personal Supports

As the assessment is focussed on those services, benefits and supports a worker will need after retirement, the Board will not consider a worker's entitlement to services, benefits and assistance such as:

- vocational rehabilitation programs and services to assist in a worker's return to work efforts (Items C11-88.00 to C11-88.60);
- vocational rehabilitation wage-loss equivalency benefits (Item C11-89.10); or
- subsistence allowances for income loss provided as a health care benefit (Item C10-83.10).

This list is not exhaustive and the Board may alter this list as required.

3. Reviews After Retirement

The Board may at its discretion, periodically review a worker's need or continued need for services, benefits and supports following the worker's retirement. Based on these reviews, the Board may confirm, adjust or discontinue the provision of these services, benefits and supports. For example, a change in the worker's compensable medical status may require the Board to modify the amount and type of services, benefits or supports needed by the worker.

EFFECTIVE DATE:	June 1, 2009
AUTHORITY:	Section 162 of the *Act*.
CROSS REFERENCES:	Chapter 6, *Permanent Disability Benefits*; Chapter 10, *Health Care*; Item C18-116.00, *Retirement Benefits – Establishment of Amounts Set Aside and Contributed*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. January 1, 2015 − Consequential amendments arising from changes to Chapter 10, *Medical Assistance, Rehabilitation Services & Claims Manual*. June 1, 2009 – Deleted references to Vocational Rehabilitation Services. June 30, 2002 − New policy that sets out how the Board will comply with section 162 of the *Act* which requires that the Board assess a worker's need or continued need for rehabilitation and health care services and personal supports, whose permanent total disability continues past retirement age. This policy applies to injuries occurring on or after June 30, 2002 and to a worker whose permanent disability first occurs on

or after June 30, 2002. This policy also applies to recurrences occurring on or after June 30, 2002.

APPLICATION: Applies on or after June 1, 2009.

APPENDIX 1

INDEX OF RETIRED DECISIONS FROM VOLUMES 1 – 6 (DECISIONS NO. 1 – 423) OF THE *WORKERS' COMPENSATION REPORTER*

EXPLANATORY NOTE:

The Board of Directors Bylaw re: Policies of the Board of Directors lists the policy manuals and other documents that are policies for purposes of the *Workers Compensation Act*. Included in the list are Decisions No. 1 – 423 in volumes 1 – 6 of the *Workers' Compensation Reporter*. These Decisions consist, for the most part, of decisions made by the former commissioners on various matters between 1973 and 1991.

In order to reduce the number of sources of policies, a strategy was approved for consolidating Decisions No. 1 – 423 into the various policy manuals, as appropriate, and "retiring" the Decisions over time.

"Retire" for this purpose means that, as of the "retirement date", the Decision is no longer current policy under the Board of Directors Bylaw.

"Retiring" does not affect a Decision's status as policy prior to the date it was "retired". A "retired" Decision therefore applies in decision-making on historical issues to the extent it was applicable prior to the "retirement date". "Retiring" also does not affect the disposition of any individual matters dealt with in a Decision.[1]

All of the Decisions from volumes 1 - 6 have been "retired" from current policy status. This Index sets out each Decision's retirement date. The final Decision to be retired from policy status was retired December 11, 2013.

Please note that policy decisions of the former Governors and the former Panel of Administrators still in effect immediately before February 11, 2003 are numbered similarly to Decisions No. 1 – 423. Many decisions of the former Governors and the former Panel of Administrators remain policies of the Board of Directors, and have not been retired.

[1] Decisions or parts of Decisions may have been replaced, either expressly or impliedly, by subsequent policies in the policy manuals or other policy documents. Under the Board of Directors Bylaw, where there is a conflict between policy in Decisions No. 1 - 423 and policy in a policy manual listed in the Bylaw, the policy in the manual is paramount. In the event of any other conflict between policies, the most recently approved policy is paramount.

DECISION NO.	TITLE	RETIREMENT DATE
01	Publication of Decisions	May 1, 2000
02	An Injured Person	February 24, 2004
03	A Claim For Industrial Disease	February 24, 2004
04	The Replacement of Eyeglasses	October 21, 2003
05	Partial Commutation of a Pension	June 17, 2003
06	The Enforcement of Accident Prevention Regulations	October 21, 2003
07	The Determination of Disability	October 21, 2003
08	The Measurement of Partial Disability	May 1, 2000
09	Publication of the Permanent Disability Evaluation Schedule	June 17, 2003
10	A Claim for Dependents Benefits	February 24, 2004
11	Communications with Unions in Matters of Safety and Health	October 21, 2003
12	A Claim to a Solicitor's Lien	June 17, 2003
13	The Provision of Rehabilitation Services	June 17, 2003
14	Rehabilitation and Re-training	May 1, 2000
15	Industrial Hygiene and Cominco Ltd.	October 21, 2003
16	*The Criminal Injuries Compensation Act*	October 21, 2003
17	Disablement Following Unauthorized Surgery	February 24, 2004
18	Dependent's Allowances	June 17, 2003
19	Industrial Hygiene and Cominco Ltd.	June 17, 2003
20	The Payment of Claims Pending Appeals by Employers	October 21, 2003
21	The Re-opening of a Commuted Pension	October 21, 2003

DECISION NO.	TITLE	RETIREMENT DATE
22	The Measurement of Partial Disability	May 1, 2000
23	A Penalty Assessment	October 21, 2003
24	The Revision of Appeal Procedures	May 1, 2000
25	Boards of Review	June 17, 2003
26	Coverage of Workmen's Compensation	January 1, 2003
27	An Application for Re-Opening	June 17, 2003
28	Oral Enquiries on Appeals to the Commissioners	May 1, 2000
29	The Re-Opening of Decisions	October 21, 2003
30	A Claim for Death by Suicide	June 17, 2003
31	Unemployment Insurance Benefits	June 17, 2003
32	The Employment Relationship (Taxis)	January 1, 2003
33	The Measurement of Partial Disability and Proportionate Entitlements	May 1, 2000
34	The Accident Prevention Regulations and the Prosecution of Workers	October 21, 2003
35	Procedure on Appeals	June 17, 2003
36	Industrial Hygiene	June 17, 2003
37	The Replacement of Eyeglasses	June 17, 2003
38	Compensation for Loss of Hearing	June 17, 2003
39	The Coverage of Workmen's Compensation	October 21, 2003
40	The Calculation of Compensation and Recurrence of Disability	June 17, 2003
41	The Composition of a Medical Review Panel	February 24, 2004
42	Changes in the *Workmen's Compensation Act*	June 17, 2003
43	The *Workmen's Compensation Amendment Act*	May 1, 2000

DECISION NO.	TITLE	RETIREMENT DATE
44	The Recurrence of Disability	October 21, 2003
45	Claims for Silicosis	June 17, 2003
46	The Consumer Price Index	May 1, 2000
47	The Commencement of the *Workmen's Compensation Amendment Act*, 1974	June 17, 2003
48	The Coverage of Workers' Compensation	February 24, 2004
49	The Coverage of Workers' Compensation	January 1, 2003
50	The Coverage of Workers' Compensation	February 24, 2004
51	A Penalty Assessment and Northwood Properties Ltd.	June 17, 2003
52	Evidence and the Standard of Proof	October 21, 2003
53	Fire Fighting and Hair	June 17, 2003
54	The Reimbursement of Expenses	October 21, 2003
55	Rehabilitation and Re-training	May 1, 2000
56	Rehabilitation Provisions for a Surviving Dependent Spouse	June 17, 2003
57	The Termination of Benefits at a Future Date	June 17, 2003
58	Industries and Classifications	January 1, 2003
59	Lump Sums in Fatal Cases	October 21, 2003
60	Appeals to Boards of Review	October 21, 2003
61	Employers' Reports of Injuries	June 17, 2003
62	Rehabilitation and Re-training	October 21, 2003
63	The Supply of In-File Information	June 17, 2003
64	Pensions for Widows aged 40 to 49 years	June 17, 2003
65	Cost Shifting Between Classes	February 24, 2004

DECISION NO.	TITLE	RETIREMENT DATE
66	Boards of Review	June 17, 2003
67	The Commutation of Pensions	May 1, 2000
68	The Maximum Wage Rate	May 1, 2000
69	Legal Fees	February 24, 2004
70	Boards of Review	October 21, 2003
71	The Industrial Hygiene Regulations	June 17, 2003
72	The Reinstatement of Pensions	June 17, 2003
73	Transcripts of Interviews	May 1, 2000
74	Unborn Children	June 17, 2003
75	Canada Pension Plan Benefits	June 17, 2003
76	Dependents Resident Abroad	June 17, 2003
77	Criminal Injuries Compensation	February 24, 2004
78	Multiple Disabilities and the Determination of the Maximum	June 17, 2003
79	Time Limit on Appeals	May 1, 2000
80	Safety Head Gear	October 21, 2003
81	The Recurrence of Disability	June 17, 2003
82	The Consumer Price Index	May 1, 2000
83	Cost of Living Increases and Commutations	October 21, 2003
84	Industrial Noise	June 17, 2003
85	Funeral Expenses	June 17, 2003
86	Disablement from Vibrations	October 21, 2003
87	A Common-Law Wife	October 21, 2003

DECISION NO.	TITLE	RETIREMENT DATE
88	The Application of Consumer Price Index Increases to Re-Instated Pensions under section 25A	June 17, 2003
89	Personal Care Allowances	May 1, 2000
90	A Common-Law Wife	June 17, 2003
91	Boards of Review and the Pension Plan	May 1, 2000
92	Allowances to Claimants	May 1, 2000
93	Industrial Diseases	June 17, 2003
94	Industrial Diseases	May 1, 2000
95	The Measurement of Partial Disability	October 21, 2003
96	Appeal Procedures	June 17, 2003
97	The Charging of Costs for Injuries Occurring in Connection with Treatment	October 21, 2003
98	Remarriage Allowances	May 1, 2000
99	Degeneration of Spine	January 1, 2010
100	Inspection Visits	June 17, 2003
101	Contagious Diseases	February 24, 2004
102	Disablement Through Exhaustion	February 24, 2004
103	Safety Awards	June 17, 2003
104	The Commutation of Pensions	June 17, 2003
105	The Future Employment of a Worker Disabled by a Compensable Injury of Industrial Disease	June 17, 2003
106	A One-Man Company	May 1, 2000
107	Termination Pay	February 24, 2004
108	The Violation of Safety Regulations by a Worker	February 24, 2004
109	The Dual System of Measurement for Injuries Involving the Spinal Column	June 17, 2003

DECISION NO.	TITLE	RETIREMENT DATE
110	Emphysema and Bronchitis	October 21, 2003
111	A Penalty for Non-Registration	January 1, 2003
112	The Consumer Price Index	May 1, 2000
113	Hearing Aids	June 17, 2003
114	Cost Shifting Between Classes	October 21, 2003
115	Employment Injuries and Natural Causes	October 21, 2003
116	The Coverage of Independent Operators	January 1, 2003
117	Adjustments According to the Consumer Price Index	May 1, 2000
118	Remarriages Allowances	May 1, 2000
119	Medical Information	May 1, 2000
120	The Coverage of Workers' Compensation and Participation in Competitions	June 17, 2003
121	Employment Injuries and Natural Causes	February 24, 2004
122	Industrial Disease	June 17, 2003
123	Changes in the *Workers Compensation Act*	May 1, 2000
124	Intoxication and Claims	October 21, 2003
125	The Commencement of *Workers Compensation Amendment Act, 1975*	May 1, 2000
126	Compensation Coverage and a Captive Road	October 21, 2003
127	Boards of Review	October 21, 2003
128	Bronchitis and Emphysema	February 24, 2004
129	Injuries and "Specific Incidents"	February 24, 2004
130	The Review of Old Disability Pensions	June 17, 2003
131	*The Criminal Injuries Compensation Act*	October 21, 2003

DECISION NO.	TITLE	RETIREMENT DATE
132	*The Criminal Injuries Compensation Act*	October 21, 2003
133	*The Criminal Injuries Compensation Act*	October 21, 2003
134	The Payment of Damages to a Worker and Subsequent Compensation Benefits	October 21, 2003
135	Compensation Decisions and the Death of the Worker	June 17, 2003
136	Compensation for Hearing Loss	May 1, 2000
137	Compensation for Hearing Loss	June 17, 2003
138	The Employment Relationship	January 1, 2003
139	Medical Aid Contracts	June 17, 2003
140	The Time Limit for Claiming Compensation	October 21, 2003
141	A One-Man Company	May 1, 2000
142	Employment Injuries and Natural Causes	October 21, 2003
143	The Maximum Wage Rate	May 1, 2000
144	The Management Role in Health and Safety	October 21, 2003
145	Employment Injuries and Natural Causes	February 24, 2004
146	An Unmarried Mother and Child	October 21, 2003
147	Health and Safety Awards	June 17, 2003
148	The Course of Employment	June 17, 2003
149	Commercial Stock Audits	January 1, 2003
150	Compensation for Compulsory Lay-off to Prevent the Carriage of Infection	October 21, 2003
151	The Apportionment of Dependents' Allowances	June 17, 2003
152	Injuries Arising out of Treatment and Other Appointments	February 1, 2004
153	Compensation Coverage for Volunteers	May 1, 2000

DECISION NO.	TITLE	RETIREMENT DATE
154	Legal Services for Rehabilitation Purposes	May 1, 2000
155	The Commutation of Pensions	May 1, 2000
156	The Review of Old Disability	June 17, 2003
157	Sexual Impotence	October 21, 2003
158	The Uses and Limitations of Sanctions in Industrial Health and Safety	October 21, 2003
159	The Consumer Price Index	May 1, 2000
160	The Calculation of Projected Loss of Earnings	May 1, 2000
161	Compensation Coverage for Volunteers	January 1, 2003
162	Personal Acts for an Employer	October 21, 2003
163	The Fishing Industry	January 1, 2003
164	Compensation for Hearing Loss	June 17, 2003
165	Compensation Coverage for Trainees	January 1, 2003
166	Adjustments According to the Consumer Price Index	May 1, 2000
167	Industrial Hygiene	June 17, 2003
168	The Disclosure of Information on Claim Files	May 1, 2000
169	An Employer or Independent Operator	January 1, 2003
170	The Fishing Industry	January 1, 2003
171	Allowances to Claimants	May 1, 2000
172	*The Criminal Injury Compensation Act*	February 24, 2004
173	*The Criminal Injury Compensation Act*	October 21, 2003
174	Time for Appeals	May 1, 2000
175	The Reimbursement of Expenses	May 1, 2000

DECISION NO.	TITLE	RETIREMENT DATE
176	The Binding Effects of Medical Review Certificates	October 21, 2003
177	Medical Research	June 17, 2003
178	*The Criminal Injury Compensation Act*	February 24, 2004
179	*The Criminal Injury Compensation Act*	October 21, 2003
180	Pollution	June 17, 2003
181	*The Criminal Injury Compensation Act*	October 21, 2003
182	The Course of Employment	February 24, 2004
183	An Employer or an Independent Operator	January 1, 2003
184	Application of the Dual System	May 1, 2000
185	Disability Assessment	October 21, 2003
186	Industrial Hygiene and Cominco Ltd.	June 17, 2003
187	The Fishing Industry	January 1, 2003
188	The Course of Employment	June 17, 2003
189	Broken Glass Claims	June 17, 2003
190	The Coverage of Workers Compensation	June 17, 2003
191	The Consumer Price Index	May 1, 2000
192	Industrial Hygiene and Cominco Ltd.	June 17, 2003
193	Adjustments According to the Consumer Price Index	May 1, 2000
194	Horseplay	February 24, 2004
195	Compensable Consequences of Work Injuries	February 24, 2004
196	Boards of Review	May 1, 2000
197	The Re-Opening of Board of Review Decisions	June 17, 2003
198	*The Criminal Injury Compensation Act*	February 24, 2004

DECISION NO.	TITLE	RETIREMENT DATE
199	The Review of Old Disability Pensions	June 17, 2003
200	Subsistence	October 21, 2003
201	Payments of Claims Pending Appeals to the Commissioners	May 1, 2000
202	Dual System of Measuring Disability	May 1, 2000
203	Legal Services for Rehabilitation Purposes	June 17, 2003
204	The Maximum Wage Rate	May 1, 2000
205	Rheumatoid Arthritis	October 21, 2003
206	Allergy Due to Red Cedar Dust	October 21, 2003
207	Bronchitis and Emphysema	February 24, 2004
208	The Awarding of Costs	October 21, 2003
209	Lunch Breaks	June 17, 2003
210	Re-Openings and New Evidence	June 17, 2003
211	The Reimbursement of Expenses	May 1, 2000
212	Commutation of Pensions	May 1, 2000
213	Bunkhouses	June 17, 2003
214	Travelling Employees	February 24, 2004
215	Consulting Firms	January 1, 2003
216	The Consumer Price Index	May 1, 2000
217	Adjustments According to the Consumer Price Index	May 1, 2000
218	Commutation of Pensions	May 1, 2000
219	Medical Review Panels	February 24, 2004
220	Proportionate Entitlement and the Dual System	May 1, 2000
221	Bronchitis and Emphysema	October 21, 2003

DECISION NO.	TITLE	RETIREMENT DATE
222	Compensable Consequences of Work Injuries	October 21, 2003
223	The Fishing Industry	January 1, 2003
224	The Fishing Industry	January 1, 2003
225	The Fishing Industry	April 1, 2006
226	The Fishing Industry	January 1, 2003
227	Broken Eyeglasses	October 21, 2003
228	Multiple Sclerosis	June 17, 2003
229	Industries and Employment	January 1, 2003
230	Unauthorized Activities	October 21, 2003
231	Osteoarthritis of the First Carpo-Metacarpal Joint in Both Thumbs of Physiotherapists	December 11, 2013
232	Cancer of Gastro-Intestinal Tract	June 17, 2003
233	Security and Investigation Services	May 1, 2000
234	Occupational Hygiene and Cominco Ltd.	June 17, 2003
235	Manpower Supply Agencies	January 1, 2003
236	Interim Adjudication	June 17, 2003
237	Complaints to the Commissioners in Respect of Compensation Claims	May 1, 2000
238	Bronchitis and Emphysema	October 21, 2003
239	Ganglia	October 21, 2003
240	Training Allowances	June 17, 2003
241	Inmates on Work Release Programmes	January 1, 2003
242	Supply of Appliances	October 21, 2003
243	Industrial Diseases	June 17, 2003
244	The Consumer Price Index	May 1, 2000

DECISION NO.	TITLE	RETIREMENT DATE
245	Adjustments According to the Consumer Price Index	May 1, 2000
246	Pulmonary Disease and “Hard Metal” Grinding	June 17, 2003
247	Workers Undergoing Custodial Care	June 17, 2003
248	Class 11	May 1, 2000
249	Recurrence of Disability	May 1, 2000
250	Industrial Diseases	June 17, 2003
251	Penalties under Section 61(2)	October 21, 2003
252	Scope of Employment	October 21, 2003
253	Replacement of Eyeglasses and Wage Loss	June 17, 2003
254	Payment of Claims Pending Appeals to the Commissioners	May 1, 2000
255	Registration of Labour Contractors as Employers	January 1, 2003
256	Scope of Employment	June 17, 2003
257	The Maximum Wage Rate	May 1, 2000
258	The Reimbursement of Expenses	May 1, 2000
259	Common-Law Spouses – “Re-Marriage Allowance”	June 17, 2003
260	Enhancement Factors and Multiple Disabilities	October 21, 2003
261	Temporary Partial Disability	June 17, 2003
262	Disability and Unemployability	June 17, 2003
263	Appeals to Medical Review Panels	October 21, 2003
264	Compensation Payable when Company Unregistered	May 1, 2000
265	The Consumer Price Index	May 1, 2000
266	Adjustments According to the Consumer Price Index	May 1, 2000

DECISION NO.	TITLE	RETIREMENT DATE
267	Section 7A: Compensation for Non-Traumatic Hearing Loss	February 24, 2004
268	Industrial Hygiene and Cominco Ltd.	June 17, 2003
269	Appeal Against Penalty Levy Amounting to $13,649.37	June 17, 2003
270	Subsection 6(5) Proportionate Entitlement	February 24, 2004
271	Re: Subsection 37(1)(e) – Charging of Costs for Enhanced Disabilities	March 1, 2005
272	Commutations	May 1, 2000
273	School Teachers and Scope of Employment	October 21, 2003
274	Industrial Hygiene and Cominco Ltd.	June 17, 2003
275	Claim for Dependent Benefits	June 17, 2003
276	Compensation for Unauthorized Surgery	June 17, 2003
277	The Consumer Price Index	May 1, 2000
278	Adjustments According to the Consumer Price Index	May 1, 2000
279	Average Earnings and Projected Loss of Earnings	October 21, 2003
280	Appeals & Referrals to the Commissioners	May 1, 2000
281	Re-Opening of Decisions & Time Limits on Appeals	June 17, 2003
282	Sections 50 and 52	October 21, 2003
283	Scope of Employment	June 17, 2003
284	The Maximum Wage Rate	May 1, 2000

DECISION NO.	TITLE	RETIREMENT DATE
285	The Reimbursement of Expenses	May 1, 2000
286	Section 6(1): Injuries Arising out of Employment	February 24, 2004
287	Proportionate Entitlement and Dual System	May 1, 2000
288	The Review of Old Disability Pensions	June 17, 2003
289	Permanent Partial Disability and Devaluation	October 21, 2003
290	The Consumer Price Index	May 1, 2000
291	Adjustments According to the Consumer Price Index	May 1, 2000
292	Scope of Employment and Sports Professionals	June 17, 2003
293	Section 54 and Refusal of Medical Examination or Treatment	October 21, 2003
294	Payment of Costs for Medical Review Reports and Examinations	June 17, 2003
295	Section 54(2)(a) Insanitary or Injurious Practices	June 17, 2003
296	Section 8 – Employment out of Province	June 17, 2003
297	Dual System and Non-Spinal Injuries	May 1, 2000
298	Appeals to Medical Review Panels	June 17, 2003
299	Hearing Aids	June 17, 2003
300	Section 52 - “Special Circumstances”	May 1, 2000
301	Single Trauma and Cancer	June 17, 2003
302	Termination and Wage Loss Benefits	June 17, 2003
303	Access to Claim Files	May 1, 2000
304	The Consumer Price Index	May 1, 2000
305	Adjustments According to the Consumer Price Index	May 1, 2000
306	Selective Employment	October 21, 2003

DECISION NO.	TITLE	RETIREMENT DATE
307	The Fishing Industry	January 1, 2003
308	The Maximum Wage Rate	May 1, 2000
309	The Reimbursement of Expenses	May 1, 2000
310	Commutation of Hearing Loss Pensions	May 1, 2000
311	Commutation of Pensions	May 1, 2000
312	Transportation Costs for Physiotherapy and the Reimbursement of Expenses	June 17, 2003
313	Overpayments	June 17, 2003
314	The Consumer Price Index	May 1, 2000
315	Adjustments According to the Consumer Price Index	May 1, 2000
316	Herniae	October 21, 2003
317	Industrial Hygiene and Cominco Ltd.	June 17, 2003
318	Stress Testing	February 24, 2004
319	Clothing Allowances	May 1, 2000
320	Continuity of Income and Assessment for Permanent Disability	February 24, 2004
321	*Workers Compensation Act*	May 1, 2000
322	The Consumer Price Index	May 1, 2000
323	Adjustments According to the Consumer Price Index	May 1, 2000
324	Personal Care Allowances	February 24, 2004
325	The Review of Old Disability Pensions	June 17, 2003
326	Industrial Diseases	October 21, 2003
327	The Maximum Wage Rate	May 1, 2000
328	The Reimbursement of Expenses	May 1, 2000

DECISION NO.	TITLE	RETIREMENT DATE
329	Industrial Health and Safety Regulations	June 17, 2003
330	Scope of Employment	February 24, 2004
331	The Consumer Price Index	May 1, 2000
332	Adjustments According to the Consumer Price Index	May 1, 2000
333	Certain Industrial Diseases	February 24, 2004
334	Boards of Review	June 17, 2003
335	Principals of Limited Companies	January 1, 2003
336	The Consumer Price Index	May 1, 2000
337	Adjustments According to the Consumer Price Index	May 1, 2000
338	Disclosure of Claim Files	May 1, 2000
339	The Maximum Wage Rate	May 1, 2000
340	The Reimbursement of Expenses	May 1, 2000
341	Industrial Hygiene and Cominco Ltd.	June 17, 2003
342	Assessment of Employers	May 1, 2000
343	Scope of Employment	June 1, 2004
344	The Consumer Price Index	May 1, 2000
345	Adjustments According to the Consumer Price Index	May 1, 2000
346	Payment of Interest	May 1, 2000
347	Oral Hearings on Appeals to the Commissioners	May 1, 2000
348	Alcoholism	February 24, 2004
349	Industrial Health and Safety Regulations	October 21, 2003
350	Commissioners' Decisions	May 1, 2000

DECISION NO.	TITLE	RETIREMENT DATE
351	Assessment of Employers	January 1, 2003
352	The Consumer Price Index	May 1, 2000
353	Adjustments According to the Consumer Price Index	May 1, 2000
354	Industrial Hygiene and Cominco Ltd.	June 17, 2003
355	Industrial Health and Safety Inspections	October 21, 2003
356	Bilateral Herniae	October 21, 2003
357	Subsistence and the Reimbursement of Expenses	June 17, 2003
358	The Maximum Wage Rate	May 1, 2000
359	The Reimbursement of Expenses	May 1, 2000
360	Out of Province Injury and Travelling to Work	October 21, 2003
361	Coverage of the Farming Industry	May 1, 2000
362	The Maximum Wage Rate	May 1, 2000
363	The Review of Old Disability Pensions	October 21, 2003
364	Retraining of Surviving Spouses	May 1, 2000
365	The Consumer Price Index	May 1, 2000
366	Adjustments According to the Consumer Price Index	May 1, 2000
367	Hearing Aids	June 17, 2003
368	Appeals	June 17, 2003
369	Appeals to Boards of Review	October 21, 2003
370	Disclosure of Board Files	May 1, 2000
371	Publication of Board Manuals	January 1, 2003
372	The Consumer Price Index	May 1, 2000

DECISION NO.	TITLE	RETIREMENT DATE
373	Adjustments According to the Consumer Price Index	May 1, 2000
374	Appeals to the Commissioners	May 1, 2000
375	The Maximum Wage Rate	May 1, 2000
376	The Reimbursement of Expenses	May 1, 2000
377	Fraudulent Claims	June 17, 2003
378	Proportionate Entitlement	October 21, 2003
379	Time Limit on Application for Compensation	February 24, 2004
380	The Consumer Price Index	May 1, 2000
381	Adjustments According to the Consumer Price Index	May 1, 2000
382	The Commutation of Pensions	February 24, 2004
383	Application of Dual System	June 17, 2003
384	Interest Payments on Retroactive Pensions	October 21, 2003
385	The Consumer Price Index	May 1, 2000
386	Adjustments According to the Consumer Price Index	May 1, 2000
387	Chiropractic Treatment	June 17, 2003
388	Assignments, Charges, or Attachments of Compensation	June 17, 2003
389	Refusals of Certificates of Fitness Under the Mines Act	May 1, 2000
390	The Maximum Wage Rate	May 1, 2000
391	The Reimbursement of Expenses	May 1, 2000
392	The Consumer Price Index	May 1, 2000
393	Appeals	May 1, 2000

DECISION NO.	TITLE	RETIREMENT DATE
394	The Dual System of Measuring Disability	October 21, 2003
395	Payments Pending Appeals	June 17, 2003
396	The Consumer Price Index	May 1, 2000
397	The Maximum Wage Rate	May 1, 2000
398	The Consumer Price Index	May 1, 2000
399	Appeals to Workers' Compensation Review Board	June 17, 2003
400	The Consumer Price Index	May 1, 2000
401	Experience Rating	January 1, 2003
402	Adjustments According to the Consumer Price Index	May 1, 2000
403	Appeals to Workers' Compensation Review Board	May 1, 2000
404	The Maximum Wage Rate	May 1, 2000
405	The Consumer Price Index	May 1, 2000
406	Recurrence of Disabilities	October 21, 2003
407	Assessment of Permanent Disabilities	February 24, 2004
408	The Consumer Price Index	May 1, 2000
409	The Maximum Wage Rate	May 1, 2000
410	Disclosure of Board Files	May 1, 2000
411	The Consumer Price Index	May 1, 2000
412	The Consumer Price Index	May 1, 2000
413	The Maximum Wage Rate	May 1, 2000
414	The Consumer Price Index	May 1, 2000
415	The Consumer Price Index	May 1, 2000

DECISION NO.	TITLE	RETIREMENT DATE
416	The Maximum Wage Rate	May 1, 2000
417	Adjustments According to the Consumer Price Index	May 1, 2000
418	The Consumer Price Index	May 1, 2000
419	Schedule B	June 17, 2003
420	The Consumer Price Index	May 1, 2000
421	The Maximum Wage Rate	May 1, 2000
422	The Consumer Price Index	May 1, 2000
423	Adjustments According to the Consumer Price Index	May 1, 2000

APPENDIX 2

OCCUPATIONAL DISEASES LISTED IN SCHEDULE 1 – ITEM C4-25.10, SECTION C.

SECTION 138(1)

	DESCRIPTION OF DISEASE	DESCRIPTION OF PROCESS OR INDUSTRY
1.	Poisoning by:	
	(1) Lead	Where there is exposure to lead or lead compounds.
	(2) Mercury	Where there is exposure to mercury or mercury compounds.
	(3) Arsenic or arsine	Where there is exposure to arsenic or arsenic compounds.
	(4) Cadmium	Where there is exposure to cadmium or cadmium compounds.
	(5) Manganese	Where there is exposure to manganese or manganese compounds.
	(6) Phosphorus, phosphine or the anti-cholinesterase action of organic phosphorus compounds	Where there is exposure to phosphorus or phosphorus compounds.
	(7) Organic solvents, including n-hexane, carbon tetrachloride, trichloroethane, trichloro-ethylene, acetone, benzene, toluene and xylene	Where there is exposure to organic solvents.

(8) Carbon monoxide	Where there is exposure to products of combustion or to any other source of carbon monoxide.
(9) Hydrogen sulphide	Where there is excessive exposure to hydrogen sulphide.
(10) Nitrous fumes, including silo-filler's disease	Where there is excessive exposure to nitrous fumes, including the oxides of nitrogen.
(11) Nitriles, hydrogen cyanide or its soluble salts	Where there is exposure to chemicals containing -CN group including certain pesticides.
(12) Phosgene	Where there is excessive exposure to phosgene, including its occurrence as a breakdown product of chlorinated compounds by combustion.
(13) Other toxic substances	Where there is exposure to such toxic gases, vapours, mists, fumes or dusts.
2. Infection caused by:	
(1) Psittacosis virus	Where there is established contact with ornithosis-infected avian species or material.
(2) Salmonella organisms, Staphylococcus aureus, or Hepatitis B virus	Where close and frequent contact with a source or sources of the infection has been established and the employment necessitates (a) the treatment, nursing or examination of or interviews with patients or ill persons, (b) the analysis or testing of body tissues or fluids, or (c) research into salmonellae, pathogenic staphylococci or Hepatitis B virus.
(3) Brucella organisms, including Undulant fever	Where there is contact with animals, animal carcasses or animal by-products.

(4) Tubercle bacillus

Where close and frequent contact with a source or sources of tuberculous infection has been established and the employment necessitates

(a) the treatment, nursing or examination of patients or ill persons,

(b) the analysis or testing of body tissues or fluids, or

(c) research into tuberculosis by a worker who,

(i) when first engaged, or after an absence from employment of the types mentioned in these regulations for a period of more than one year, when re-engaged in such employment was free from evidence of tuberculosis, and

(ii) continued to be free from evidence of tuberculosis for 6 months after being so employed, except in the case of primary tuberculosis as proven by a negative tuberculin test at time of employment. In the case of a worker previously compensated for tuberculosis, any subsequent tuberculosis after the disease has become inactive and has remained inactive for a period of 3 years or more is not be considered to have occurred as a result of the original disability,

		unless the worker is still engaged in employment listed above or the Board is satisfied that the subsequent tuberculosis is the direct result of the tuberculosis for which the worker has been compensated.
3.	Pneumoconiosis:	
	(1) Silicosis	Where there is exposure to airborne silica dust, including in metalliferous mining and coal mining.
	(2) Asbestosis	Where there is exposure to airborne asbestos dust.
	(3) Other pneumoconioses	Where there is exposure to the airborne dusts of coal, beryllium, tungsten carbide, aluminum or other dusts known to produce fibrosis of the lungs.
4.	Diffuse pleural thickening or fibrosis, whether unilateral or bilateral	Where there is exposure to airborne asbestos dust and the worker has not previously had and does not currently have collagen disease, chronic uremia, drug-induced fibrosis, tuberculosis or other infection, trauma or disease capable of causing pleural thickening or fibrosis.
5.	Benign pleural effusion, whether unilateral or bilateral	Where there is exposure to airborne asbestos dust and the worker has not previously had and does not currently have collagen disease, chronic uremia, tuberculosis or other infection, trauma or disease capable of causing pleural effusion.

6.	Cancer:	
	(1) Primary carcinoma of the lung when associated with asbestosis	Where there is exposure to airborne asbestos dust.
	(2) Primary carcinoma of the lung when associated with bilateral diffuse pleural thickening over 2 mm thick	Where there is exposure to airborne asbestos dust and the worker has not previously had collagen disease, chronic uremia, drug-induced fibrosis, tuberculosis or other infection or trauma capable of causing pleural thickening.
	(3) Primary carcinoma of the lung	Where there is exposure to airborne asbestos dust for a period of 10 years or more of employment in one or more of the following industries: (a) asbestos mining; (b) insulation or filter material production; (c) construction, where there is disturbance of asbestos-containing materials; (d) plumbing or electrical work; (e) pulp mill work; (f) shipyard work; (g) longshoring.
	(4) Mesothelioma, whether pleural or peritoneal	Where there is exposure to airborne asbestos dust.
	(5) Carcinoma, associated with asbestosis, of the larynx or pharynx	Where there is exposure to airborne asbestos dust.

(6)	Gastrointestinal cancer, including all primary cancers associated with the esophagus, stomach, small bowel, colon and rectum excluding the anus, and without regard to the site of the cancer in the gastrointestinal tract or the histological structure of the cancer	Where there is exposure to asbestos dust if, during the period between the first exposure to asbestos dust and the diagnosis of gastrointestinal cancer, there has been a period of, or periods adding up to, 20 years of continuous exposure to asbestos dust and such exposure represents or is a manifestation of the major component of the occupational activity in which the exposure occurred.
(7)	Primary cancer of the lung	Where there is prolonged exposure to any of the following: (a) aerosols and gases containing arsenic, chromium, nickel or their compounds; (b) bis (chloromethyl) ether; (c) the dust of uranium, or radon gas and its decay products; (d) particulate polycyclic aromatic hydrocarbons.
(8)	Leukemia or pre-leukemia	Where there is prolonged exposure to benzene or to ionizing radiation.
(9)	Primary cancer of the skin	Where there is (a) prolonged contact with coal tar products, arsenic or cutting oils, or (b) prolonged exposure to solar ultraviolet light.
(10)	Primary cancer of the epithelial lining of the urinary bladder, ureter or renal pelvis	Where there is prolonged exposure to beta-naphthylamine, benzidine or 4-nitrodiphenyl.
(11)	Primary cancer of the mucous lining of the nose or nasal sinuses	Where there is prolonged exposure to (a) dusts, fumes or mists containing nickel, or (b) the dusts of hard woods.

	(12)Angiosarcoma of the liver	Where there is exposure to vinyl chloride monomer.
7.	Asthma	Where there is exposure to any of the following: (a) western red cedar dust; (b) isocyanate vapours or gases; (c) the dusts, fumes or vapours of other chemicals or organic material known to cause asthma.
8.	Extrinsic allergic alveolitis (including farmers' lung and mushroom workers' lung)	Where there is repeated exposure to respirable organic dusts.
9.	Acute upper respiratory inflammation, acute pharyngitis, acute laryngitis, acute tracheitis, acute bronchitis, acute pneumonitis or acute pulmonary edema, excluding any allergic reaction, reaction to environmental tobacco smoke or effect of an infection	Where (a) there is exposure to a high concentration of fumes, vapours, gases, mists or dusts of substances that have irritating or inflammatory properties, and (b) the respiratory symptoms occur within 48 hours of the exposure, or if there is exposure to nitrogen dioxide or phosgene, within 72 hours of the exposure.
10.	Metal fume fever	Where there is exposure to the fumes of zinc or other metals.
11.	Fluorosis	Where there is exposure to high concentrations of fluorine or fluorine compounds, whether in gaseous or particulate form.
12.	Neurosensory hearing loss	Where there is prolonged exposure to excessive noise levels.

13.	Bursitis:	
	(1) Knee bursitis (inflammation of the prepatellar, suprapatellar or superficial infrapatellar bursa)	Where (a) there is repeated jarring impact against the involved bursa, or (b) there are significant periods of kneeling on the involved bursa.
	(2) Shoulder bursitis (inflammation of the subacromial or subdeltoid bursa)	Where there is frequently repeated or sustained abduction or flexion of the shoulder joint greater than 60º and where such activity represents a significant component of the employment.
14.	Tendinopathy:	
	(1) Hand-wrist tendinopathy	Where there is use of the affected tendon or tendons to perform a task or series of tasks that involve any 2 of the following and where such activity represents a significant component of the employment: (a) frequently repeated motions or muscle contractions that place strain on the affected tendon or tendons; (b) significant flexion, extension, ulnar deviation or radial deviation of the affected hand or wrist; (c) forceful exertion of the muscles used in handling or moving tools or other objects with the affected hand or wrist
	(2) Shoulder tendinopathy	Where there is frequently repeated or sustained abduction or flexion of the shoulder joint greater than 60º and where such activity represents a significant component of the employment.

15.	Decompression sickness	Where there is exposure to increased air pressure.
16.	Contact dermatitis	Where there is excessive exposure to irritants, allergens or sensitizers ordinarily causative of dermatitis.
17.	Hand-arm vibration syndrome	Where there has been at least 1 000 hours of exposure to tools or equipment that causes the transfer of significant vibration to the hand or arm of the worker.
18.	Radiation injury or disease:	
	(1) Due to ionizing radiation	Where there is exposure to ionizing radiation.
	(2) Due to non-ionizing radiation:	
	(a) conjunctivitis or keratitis	Where there is exposure to ultraviolet light.
	(b) cataract or other thermal damage to the eye	Where there is excessive exposure to infrared, microwave or laser radiation.
19.	Erosion of incisor teeth	Where there is exposure to acid fumes or mist.

20.	Infection that is (1) caused by communicable viral pathogens, and (2) the subject of one or more of the following: (a) notice given under section 52(2) of the *Public Health Act*; (b) a state of emergency declared under section 9(1) of the *Emergency Program Act*; (c) a state of local emergency declared under section 12(1) of the *Emergency Program Act*; (d) an emergency declared under section 173 of the *Vancouver Charter*.	Where (a) there is a risk of exposure to a source or sources of infection significantly greater than that to the public at large, (b) the risk of exposure occurs during the applicable notice or emergency under column 1, and (c) the risk of exposure occurs within the geographical area of the applicable notice or emergency under column 1.

APPENDIX 3

PERMANENT DISABILITY EVALUATION SCHEDULE

Rehabilitation Services & Claims Manual
Volume II

WorkSafeBC

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I. Introduction

The Permanent Disability Evaluation Schedule (the "Schedule") was developed by WorkSafeBC based on consideration of expert medical opinion, current medical/scientific literature and schedules from other jurisdictions and organizations, including but not limited to various editions of the American Medical Association *Guides to the Evaluation of Permanent Impairment* (the "AMA Guides").

As per section 195(3) of the *Act*, the Schedule is used for guidance in the measurement of permanent partial disability under section 195 of the *Act*. The Schedule attributes a percentage of total disability to each of the specified disablements. For example, an amputation of the arm, middle, third of humerus, is indicated to be 65%. When that percentage rate is applied, it means that a worker will receive permanent disability benefits under section 195 based on 65% of 90% of average net earnings as determined by the *Act*.

The Schedule does not necessarily determine the final amount of the section 195(1) permanent disability benefits. The Board may take other factors into account. Thus, the Schedule provides a guideline or starting point for the measurement of disability, rather than a fixed result (see Item C6-39.00, *Section 195 Permanent Partial Disability Benefits*).

It is not possible to list every disability in the Schedule. However, the Schedule can be used for guidance if a disability is similar to one that is listed. If a disability is not covered in the Schedule, other information regarding disability assessment may be consulted, including expert medical opinion, current medical/scientific literature and schedules from other jurisdictions and organizations.

II. Application of the Schedule

A. Amputations

In assigning a percentage of disability to any amputation, it must be assumed that the stump is structurally perfect, that it is well padded, that the scar is properly placed and that there is no undue tenderness on areas which are subject to pressure.

In the case of major limb amputations, disability ratings assigned should have regard to the type and probable usefulness of the prosthesis to which they are adaptable.

B. Age Adaptability

The percentage of total disability derived by use of the Schedule is modified by the application of an age variable. This age adaptability factor is used for workers over the age of 45 where the disability is calculated in accordance with the Schedule. The disability rating is increased by 1% of the assessed disability for each year over 45 up to a maximum of 20% of the assessed disability.

Example:

> Permanent disability benefits effective at age 55
> Scheduled disability is 50% of total disability
> Age adaptability factor 10% of 50% = 5% of total disability
> Disability assessed at 55% of total disability

The worker's age at the effective date of the worker's permanent disability benefits is used, not the worker's age at the time of the injury.

The age adaptability factor is not applied where the Schedule provides another method of taking the worker's age into account (e.g. when rating traumatic bilateral hearing loss).

C. Enhancement

Where a worker has an additional disability which pre-existed the injury or the injury causes more than one disability, the Board, in certain situations, increases the overall percentage of disability that would otherwise be provided. This is known as the "enhancement factor".

Enhancement is only applied to this Schedule. An enhancement factor is not applied to non-Scheduled permanent disability benefits, such as for chronic pain.

The Board applies enhancement in the following limited situations:

1. Arms

An enhancement factor is applied to disabilities on opposite sides of the body involving both arms. For example, a right wrist and a left wrist, or a left shoulder and a right elbow, etc. An enhancement factor of 50% of the lesser arm disability is added to the total of the percentages rated for each separate arm disability.

2. Legs

An enhancement factor is applied to disabilities on opposite sides of the body involving both legs. For example, a right ankle and a left ankle, or a right ankle and a left knee, etc. An enhancement factor of 50% of the lesser leg disability is added to the total of the percentages rated for each separate leg disability.

3. Assisted Ambulation

An enhancement factor is applied to disabilities in different parts of the body that permanently impede the worker from using required devices for assisted ambulation (e.g. a cane, walker or wheel chair). For example, disability to a right wrist and a left ankle in combination may impede the use of a cane. An enhancement factor of 50% of the lesser disability is added to the total of the percentages rated for each separate disability.

4. Spine

An enhancement factor may be applied where disability of the spine is shown to have been enhanced by another limb disability. An enhancement factor is not applied to two or more disabilities of the spinal column in combination. A factor of 50% of the disability attributed to the spine is added. Therefore, if the disability in the back is 10%, and the sum of the other disabilities is 16%, the enhancement factor is 5% and the total disability is rated at 31%.

5. Digits

An enhancement factor is applied to disabilities involving the digits (i.e. thumb(s) and/or finger(s)) as set out in the section V. of the Schedule, “Hands”.

6. Vision Disability

An enhancement factor is applied to disabilities involving the eyes, as set out in section XII, “Vision Disability”.

7. Bilateral Traumatic Hearing Loss

An enhancement factor is applied to bilateral traumatic hearing loss, as set out in section XIII, “Traumatic Hearing Loss” under heading B. Bilateral Traumatic Hearing Loss. Note that an enhancement factor also applies to bilateral non-traumatic hearing loss, as required under the *Act*, see section XIV, “Non-Traumatic Hearing Loss (Schedule 2/Section 145 of the *Act*)”.

D. Devaluation

Where the sum of the Scheduled percentages allocated to several disabilities in the same limb exceeds their actual combined effect, a downward adjustment is required. This is known as “devaluation”.

Multiple disabilities involving one limb cannot exceed the amputation value of that limb. As a result, disabilities of the arm cannot exceed 70% and disabilities of the leg cannot exceed 65%.

These principles also apply to disabilities of the eyes, as set out in section XII, “Vision Disability”.

E. Dominant Side

Whether a permanent disability occurs in a worker’s dominant side (e.g. the right hand of a worker who is right-handed), is not a factor considered in rating permanent disability.

F. Loss of Strength

As a general rule, loss of strength is included in the disability ratings attributed to each impairment in the Schedule.

In rare cases, where the mechanical, anatomical, or pathological cause of the loss of strength is distinct from the other impairments in the Schedule, the loss of strength will be rated separately and added to other ratings in the Schedule.

For example, a loss of strength rating may be added to an amputation rating where the loss of strength results from tissue loss above the amputation site. While the amputation rating reflects any consequent loss of strength in the amputated limb, it does not reflect loss of strength caused by the tissue loss.

Loss of strength may also be rated separately and added to ratings for the following conditions:

- Miscellaneous Conditions and Surgical Procedures: Section III, V, and VI;
- Cold Intolerance: Section V. Hands;
- Osteoarthritis: Section VI. Lower Extremity; and
- Fractures of the Pelvis: Section VII. Pelvis.

G. Range of Motion Method

The Schedule provides for certain permanent disabilities of the upper extremity, hands, lower extremity and the spine to be rated using the range of motion method. Under this method, disability is assessed by comparing a worker's post-injury range of motion to either the range of motion on the worker's uninjured side or Scheduled normal range of motion values if there is pathology on the opposite side. Range of motion can be measured actively or passively. Active range of motion refers to the extent a joint can be moved using the muscles surrounding the joint, without assistance. Passive range of motion refers to the extent a joint can be moved by an external force. Only active range of motion measurements are used to calculate ratings in this Schedule. The Board uses the range of motion method, rather than other methods, because it allows for impairment to be objectively rated and linked to loss of function.

H. Muscle Wasting/Swelling

Muscle wasting (atrophy) and/or swelling may result in a change in size, but that change in size alone is not an indicator of disability. Any disability that may arise in connection with muscle wasting and/or swelling is reflected in the disability ratings provided for loss of strength and/or loss of range of motion.

I. Loss of Sensation in Surgical or Other Traumatic Scars

Loss of sensation in surgical or other traumatic scars is not generally significant and does not merit consideration for permanent disability benefits.

III. Upper Extremity

A. Amputations

	Percentage
Proximal, third of humerus or disarticulation at shoulder	70
Middle, third of humerus	65
Distal, third of humerus to biceps insertion	60
Insertion of biceps to middle of forearm	57
Middle of forearm to wrist	54

B. Immobility of Joints (Arthrodesis or Functional Ankylosis)

	Percentage
Shoulder, complete with no scapular movement (frozen shoulder)	35
Flexion	14
Extension	3.5
Abduction	7
Adduction	3.5
External Rotation	3.5
Internal Rotation	3.5
Shoulder, gleno-humeral fusion, scapula free	20
Elbow	20
Pronation and supination, complete	10
Pronation alone	6
Supination alone	4
Wrist	12.5
Flexion	4
Extension	4
Radial Deviation	2.25
Ulnar Deviation	2.25

C. Partial Loss of Range of Motion

Disability from partial loss of range of motion in the upper extremity is proportional to the amount of movement lost, applied to the complete immobility rating:

$$\frac{loss\ of\ range\ of\ motion}{normal\ range\ of\ motion} \times immobility\ rating\ = loss\ of\ range\ of\ motion\ rating$$

The following principles apply when rating partial loss of range of motion in an upper extremity:

- A loss of range of motion of five degrees or less generally does not impair a worker's earning capacity to an ascertainable degree.

- When assessing loss of range of motion in an upper extremity, there is usually a normal side for comparison. In instances when a normal side does not exist, reference is made to the normal range of motion values set out below.

- Loss of hyperextension in an unusually flexible worker does not result in a disability. The loss of range of motion in the injured extremity of an unusually flexible worker is compared with the normal range of motion values set out below.

Upper Extremity Normal Range of Motion Values

	Degrees
Shoulder	
Flexion	158
Extension	53
Abduction	170
Adduction	50
*Internal Rotation	70
*External Rotation	90

*Arm in abduction of 90 degrees; if unable to achieve this degree of abduction, internal and external rotation is measured, with the arms at the highest abduction available to injured shoulder bilaterally.

	Degrees
Elbow	
Flexion	146
Extension	0
Forearm	
Pronation	71
Supination	84
Wrist	
Flexion	73
Extension	71
Radial Deviation	19
Ulnar Deviation	33

D. Loss of Strength

This section sets out how to rate loss of strength where loss of strength is the only permanent impairment in the upper extremity or when a loss of strength is rated separately and added to other ratings in the Schedule.

To determine when loss of strength is rated separately and added to other ratings in the Schedule, see Section II, “Application of the Schedule”, under heading F. Loss of Strength.

A disability rating for loss of strength in the upper extremity is assessed per arm. Such a rating is only to be applied if there is strong, consistent, objective evidence of loss of strength. In addition, there must be a clear pathological explanation for the weakness.

In cases where loss of strength is rated separately and added to other ratings in the Schedule, the loss of strength is rated using the Medical Research Council (MRC) Scale. The MRC Scale is a numerical rating scale used to assess muscle power on a scale from 0 (no contraction) to 5 (normal power) in relation to the maximum expected for the muscle being tested.

This section applies to loss of strength in the upper extremities with the exception of the hands. Guidance on assessing loss of strength in the hands is provided in section V, “Hands”, under heading D. Loss of Strength.

Loss of strength in the upper extremity is assessed as follows:

MRC Scale	Definition	PDES Percentage
5	Normal power	0
4+	Active movement against gravity and strong resistance	1
4	Active movement against gravity and moderate resistance	2
4-	Active movement against gravity and slight resistance	3
3	Movement possible against gravity, but not against added resistance	5
2	Movement possible, but not against gravity (test joint in its horizontal plane)	7
1	Flicker or trace of contraction, but no movement	7
0	No contraction	7

E. Miscellaneous Conditions and Surgical Procedures

Unless otherwise specified, disability ratings for miscellaneous conditions and surgical procedures involving the upper extremity are added to the other applicable ratings for immobility, loss of range of motion and/or loss of strength in the affected extremity.

Percentage

Shoulder replacement arthroplasty 6.5

Elbow replacement arthroplasty..... 5.8

Acromioclavicular (AC) joint resection 3

Sternoclavicular joint resection 3

Radial head resection (with or without prosthetic replacement)..... 3

Resurfacing or partial arthroplasties merit the same disability rating as a complete arthroplasty.

IV. Hand-Arm Vibration Syndrome

To measure the extent of any permanent disability resulting from hand-arm vibration syndrome, the evaluation is carried out in the following manner:

1. The vascular, sensorineural and musculoskeletal impairments of the worker are assessed in reference to the following table:

Elements	Process (Assess each hand separately)	Points Applied
Vascular Element	Assess vascular elements: blanching of fingers in cold temperature, pain, swelling, ulcers, gangrene and amputations: Distal phalange on index, middle and ring finger = 1 point each Middle phalange on index, middle and ring finger = 1 point each Proximal phalange on index, middle and ring finger = 2 points each All phalanges on little finger = 1 point All phalanges on thumb finger = 1 point Distal half of palm (top) = 1 to 2 points Proximal half of palm (bottom) = 1 point	17 points max per hand
	ADD: Double value of sum of above if there is evidence of trophic changes (i.e., ulcers)	17 points max per hand
	MAXIMUM points for Vascular element	34 points per hand
Sensorineural Element	Assess sensorineural impairment (evidence of numbness, tingling and reduced sensory perception)	2 points max per hand
	Assess manual dexterity (i.e., difficulty with buttons and writing) Additional 1 to 2 points per hand if reduction occurs	2 points max per hand
	MAXIMUM points for sensorineural element	4 points per hand
Musculoskeletal Element	Assess musculoskeletal impairment (loss of grip strength)	2 points max per hand
MAXIMUM points from vascular, sensorineural and musculoskeletal elements for each hand		40 points per hand
Add total points for both hands		

2. The worker's percentage of disability is rated using the assessment of impairment as follows:

Points	**Percentage**
1 – 4	1
5 – 15	2
16 – 20	4
21 – 30	6
31 – 35	8
36 – 40	10
41 and up	11 – 20

V. Hands

A. Amputation of Digits

Five hand charts are included at the end of the “Hands” section of the Schedule. These charts set out the percentages of total disability available for amputation of digits. A “digit” may be either a finger or a thumb.

Hand charts 1 and 2 set out the percentages of disability in respect of an amputation of the thumb or a single finger.

Hand charts 3 to 5 set out the percentages of disability for multiple finger amputations. Charts 3 to 5 include enhancement factors for multiple finger disabilities.

Where a thumb and one or more fingers are amputated, the percentage of disability for the thumb is determined and the percentage of the disability for the finger(s) is determined. An enhancement factor of 100% of the lesser of the thumb disability rating or the combined finger disability rating is then added.

The following principles apply to assessment of disability from amputation of digits:

- The amputation value of a digit includes loss of sensation at the amputation site.
- Generally, there must be shortening of the bone before permanent disability benefits are provided for amputation of a digit. However, complete loss of the digital pulp is considered to be equivalent to an amputation of one-quarter of the distal phalanx.
- Amputations of a phalanx or a metacarpal are assessed in fractions:
    - one-quarter loss
    - one-third loss
    - one-half loss
    - two-thirds loss
    - three-quarters loss
    - complete loss
- Less than one-quarter loss of a phalanx is not considered to be a disability, because such a loss does not usually have an impact on earning capacity.
- Greater than three-quarters loss of the phalanx is considered to be equivalent to an amputation of the whole phalanx.
- When a phalanx is partially amputated, the amputation value of the remaining phalanx is used in the calculation for any additional disability rating in respect of that phalanx.

B. Immobility of Joints (Arthrodesis or Functional Ankylosis)

Immobility of the interphalangeal (IP) joint, metacarpophalangeal (MCP) joint or the carpometacarpal (CMC) joint of the thumb, in good functional position, is accorded one-half of the amputation value at those levels.

Immobility of the distal interphalangeal (DIP) joint, proximal interphalangeal (PIP) joint or MCP joint of a finger, in good functional position, is accorded three-quarters of the amputation value at those levels.

Immobility of a joint in poor functional position may, on a judgment basis, approach the value of an amputation.

C. Partial Loss of Range of Motion

1. General

Partial loss of range of motion in the digits is calculated as set out below under items 2 to 4.

The following principles apply to assessment of disability from partial loss of range of motion:

- A loss of range of motion of five degrees or less generally does not impair a worker's earning capacity to an ascertainable degree.
- For assessment of loss of range of motion in the finger and thumb joints, comparison is made with the corresponding joints of the opposite hand. If the latter are also abnormal or are not available, then the findings would be compared to the normal range of motion values set out in item 5 below.
- Loss of hyperextension in an unusually flexible worker does not result in a disability. The loss of range of motion in the injured digit of an unusually flexible worker would be compared with the normal range of motion values set out below.

2. Finger(s)

Partial loss of range of motion in the finger(s) is calculated as:

$$\frac{loss\ of\ range\ of\ motion}{normal\ range\ of\ motion} \times {}^{3}/_{4} \times total\ amputation\ value\ of\ the\ joint(s)$$

This formula is used as it is normally considered that a fused finger joint is equal to three-quarters of the value of an amputation at the same level.

When assessing partial loss of range of motion in more than one finger, the appropriate multiple finger chart is used to determine the amputation value of the joints concerned, thus building in any enhancement factor.

3. Thumb Only

Partial loss of range of motion in the thumb is calculated as:

$$\frac{loss\ of\ range\ of\ motion}{normal\ range\ of\ motion} \times {}^{1}/_{2} \times amputation\ value\ of\ the\ joint$$

This formula is used as it is normally considered that a fused thumb joint is equal to one-half of an amputation at the same level.

4. Thumb and Finger(s)

When assessing partial loss of range of motion in a finger and a thumb, hand charts 1 and 2 are used. An enhancement factor of 100% of the lesser of the thumb disability rating or the finger disability rating is then added.

When assessing partial loss of range of motion in the thumb (hand chart 1) and multiple fingers (hand charts 3 to 5), an enhancement factor of 100% of the lesser of the thumb disability rating or the combined finger disability rating is then added.

5. Digit Normal Range of Motion Values

		Degrees
Fingers		
DIPJ	Flexion	80
	Extension	0
PIPJ	Flexion	100
	Extension	0
MPJ	Flexion	90
	Extension	0

		Degrees
Thumb		
IPJ	Flexion	81
	Extension	0
MPJ	Flexion	53
	Extension	0
CMCJ	Flexion	15
	Extension	50
	Palmar Abduction	50

D. Loss of Strength

This section sets out how to rate loss of strength where loss of strength is the only permanent impairment in the hands or when a loss of strength is rated separately and added to other ratings in the Schedule.

To determine when loss of strength is rated separately and added to other ratings in the Schedule, see Section II, “Application of the Schedule”, under heading F. Loss of Strength.

A disability rating for loss of strength in the hands is assessed per hand. Such a rating is only to be applied if there is strong, consistent, objective evidence of loss of strength. In addition, there must be a clear pathological explanation for the weakness.

The following formula is used to assess total percentage loss of hand strength:

$$\left(1/3\left(\frac{pinch\ grip\ loss\ of\ strength}{normal\ pinch\ grip\ strength}\right)+\left(\frac{hand\ grip\ loss\ of\ strength}{normal\ hand\ grip\ strength}\right)\right)\times 100 = total\ percentage\ loss\ of\ strength$$

Total percentage loss of hand strength amounts to percentage of total disability as set out in the following table:

Total Percentage Loss of Strength	Percentage (of Total Disability)
20 – 40	3
41 – 70	6
71 – 100	9

V. Hands

The following principles apply to rating loss of hand strength:

1. The percentage of disability for total loss of hand strength is equal to one-third of the measured pinch grip strength loss, plus 100% of the measured hand grip strength loss.
2. With unilateral strength loss, comparison is made with the uninjured side as the normal value.
3. With bilateral strength loss, comparison is made with the Table of Average Grip and Pinch Strength, attached as Appendix A.
4. The highest hand and pinch grip strength recorded is used in the calculations above.

E. Loss of Sensation

A disability rating for loss of sensation in the hands is only to be applied if there is strong, consistent, objective evidence of loss of sensation that is not taken into account by the amputation or loss of range of motion value, and not covered by peripheral nerve ratings or nerve root conditions.

For sensory loss due to peripheral nerve injury, see Section VIII, “Peripheral Nerve Conditions”.

For sensory loss due to nerve root injury, see Section IX, “Nerve Root Conditions”.

1. Two-Point Discrimination Sensory Loss

Two-point discrimination findings are measured on the radial and ulnar sides of a phalanx. The percentage of disability for sensory loss on each side is then assessed based on the amputation value of the most distal remaining phalanx, with reference to the applicable Hand Chart, as follows:

Rating Scale	Two Pt. Discrimination	% of Amputation Value
3	6 mm or less	0
2	7 − 15 mm	12.5
1	more than 15 mm with complete anesthesia (12.5% of amputation value if incomplete anesthesia)	25

If both radial and ulnar two-point discrimination are greater than 15 mm, sensory loss is rated at up to 50% of the amputation value of the digit distal to the site of nerve division, less any other value for the phalanx being assessed.

2. Total Sensory Loss

When the fingers lose total sensitivity, a rating of up to the full amputation value of the most distal remaining phalanx may be made.

F. Cold Intolerance

If a worker has been diagnosed with cold intolerance which is associated with a compensable hand injury, a disability rating for cold intolerance may be provided. Disability from cold intolerance is calculated as 50% of the total value of the hand for other rateable conditions (e.g. loss of range of motion, loss of strength), up to a maximum of 1% of total disability, per hand.

Note that cold intolerance is only considered to result in disability when it is associated with a hand injury, because such a condition may result in impairment of fine motor function. Cold intolerance associated with injuries to other parts of the body (e.g. the feet) can generally be managed (e.g. through the use of heated socks), and is not considered to result in disability.

G. Deformity

Percentage

Swan neck deformity of the finger, without surgical intervention 2

Digit disability from active ulnar or radial deviation:

Deviation	Degrees	% Digit Disability*
Mild	< 10	10
Moderate	10 – 30	20
Severe	> 30	30

* Multiply by the amputation value of the digit(s), using the applicable Hand Chart, to determine the percentage of total disability due to deformity.

Digit disability from rotational deformity:

Digit Rotational Deformity	Degrees	% Digit Disability*
Mild	< 15	20
Moderate	15 – 30	40
Severe	> 30	60

* Multiply by the amputation value of the digit(s), using the applicable Hand Chart, to determine the percentage of total disability due to deformity.

H. Miscellaneous Conditions and Surgical Procedures

Unless otherwise specified, disability ratings for miscellaneous conditions and surgical procedures involving the hands are added to the other applicable ratings for immobility, loss of range of motion, loss of strength, loss of sensation and/or deformity in the affected hand.

Percentage

Resection or prosthetic replacement of carpal bone 2

Resection or prosthetic replacement of 2 or more carpal bones 4

Rupture of the ulnar collateral ligament of the MCP joint of the thumb (e.g. gamekeeper's thumb or skier's thumb) 2.5

Carpal instability will be assessed on the basis of loss of structure and function or anatomicophysiological deficit as measured by loss of range of motion, loss of strength or structural loss.

Joint replacement value for either the MCP or CMC joint is 0.5 times the immobility rating for the joint.

I. Hand Charts

The hand charts set out the percentages of total disability available for amputation of digits.

Charts 1 and 2 set out the percentages of disability in respect of an amputation of the thumb or a single finger.

Charts 3 to 5 set out the percentages of disability for multiple finger amputations. These charts include enhancement factors for multiple finger disabilities.

Digits are referred to as thumb, index, long, ring and little. Metacarpals are referred to as first, second, third, fourth and fifth. A metacarpal and its digit are referred to as a ray and rays are numbered from one to five.

Percentages of disability for amputation of digits are added moving distal to proximal.

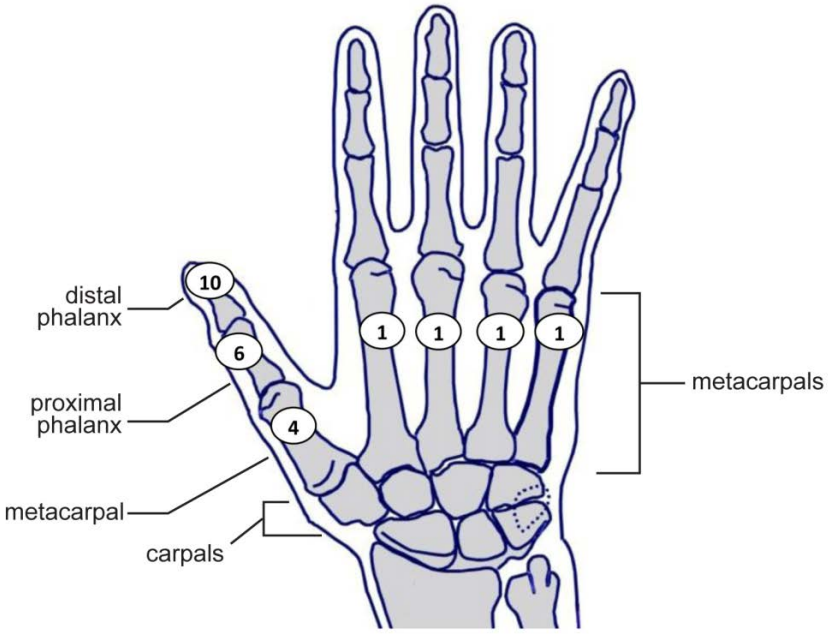

CHART 1: Thumb and Metacarpals

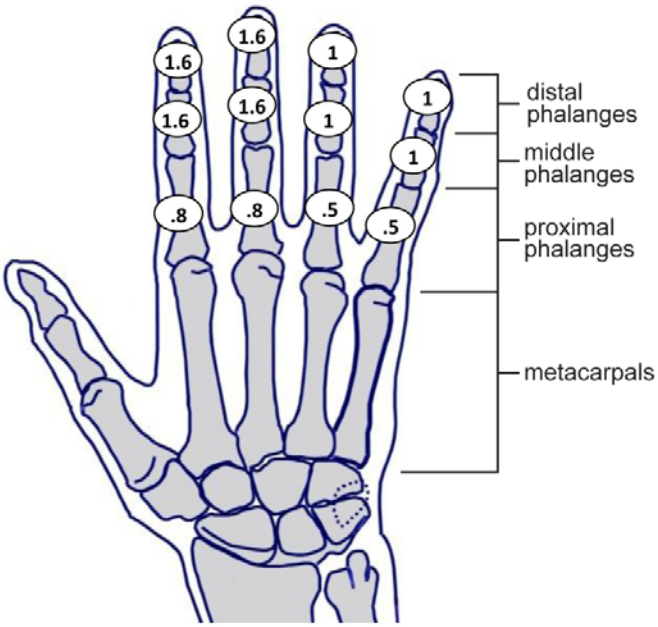

CHART 2: Single Finger

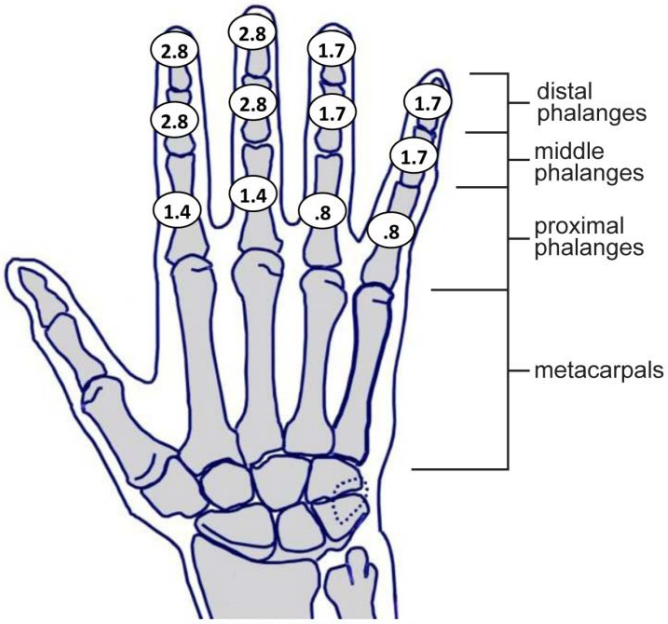

CHART 3: Two Fingers

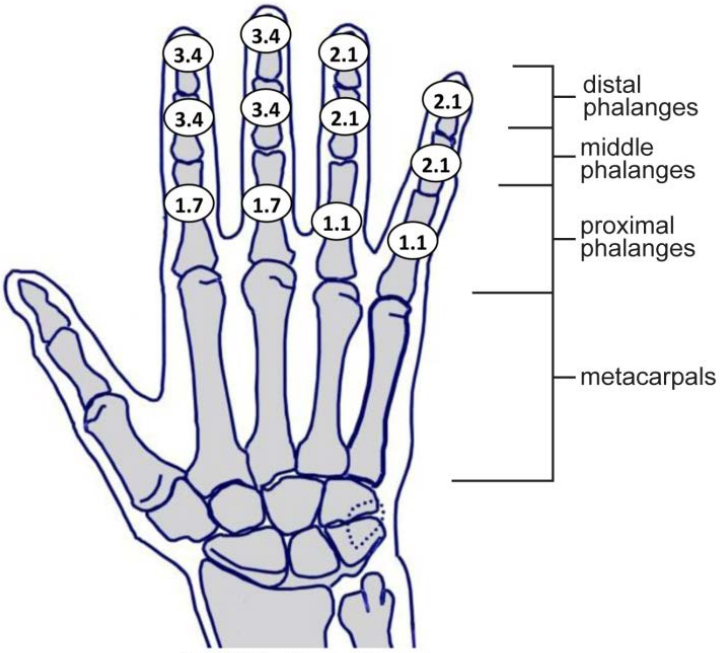

CHART 4: Three Fingers

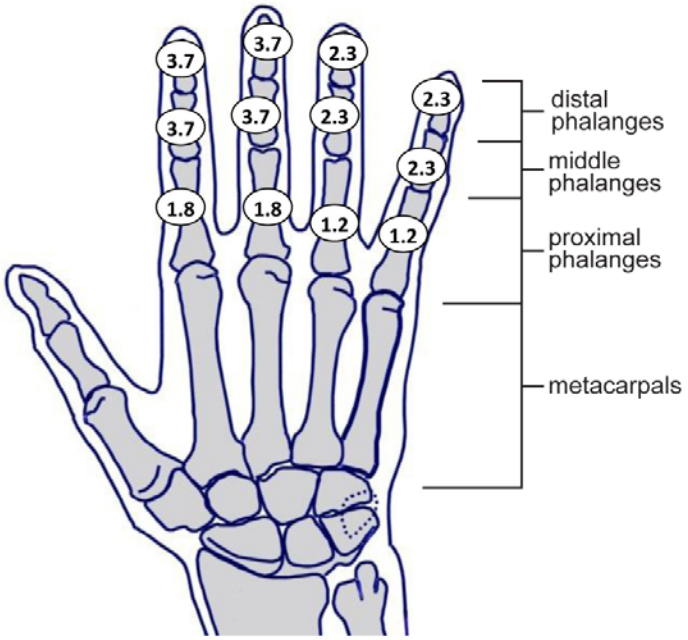

CHART 5: Four Fingers

VI. Lower Extremity

A. Amputations

	Percentage
Hip disarticulation or short stump	65
Thigh, site of election or end bearing (requiring false knee joint)	50
Short below knee stump suitable for conventional B.K. prosthesis	45
Below knee, suitable for B.K. prosthesis (Patellar bearing)	35
Leg, at ankle end bearing (Syme's Amputation)	25
Midtarsal (Chopart's Amputation)	20
Tarsometatarsal (Lisfranc's Amputation)	15
Toes, all toes	5
Toes, great	2.5
with head of metatarsal	5
Toes, great at IP joint	1
Toes, other than great, each	0.5
metatarsal, each	0.5
Toe, little with metatarsal	2

B. Immobility of Joints (Arthrodesis or Functional Ankylosis)

	Percentage
Hip	30
Flexion	9
Extension	2
Abduction	7
Adduction	3
External Rotation	6
Internal Rotation	3
Knee	25
Ankle	12
Foot	
Talocalcaneal arthrodesis	4.25
Midtarsal arthrodesis	2.75
Triple arthrodesis	7
Lisfranc's (tarsometatarsal) fusion	4
Great toe, MP joint	1.25
Great toe, IP joint	0.5

C. Shortening Causing a Difference in Leg Length

	Percentage
1.5 cm or less	0
1.6 cm to 2.5 cm	2
2.6 cm to 3.5 cm	3
3.6 cm to 4.5 cm	4
4.6 cm to 5.5 cm	6
5.6 cm to 6.5 cm	8
6.6 cm to 7.4 cm	10
7.5 cm or more	15

D. Ligamentous Laxity

Ligamentous laxity is generally assessed based on a comparison to the opposite side of the body. However, if there is pre-existing pathology in the opposite side of the body, other indicators of soft tissue laxity are considered.

	Percentage
Ligamentous Laxity of Knee	
ACL or PCL	
Grade I/Mild (5 – 9 mm)	1.67
Grade II/Moderate (10 – 14 mm)	3.34
Grade III/Marked (15 mm or more)	5
MCL or LCL	
Grade I/Mild (5 – 9 mm)	0.83
Grade II/Moderate (10 – 14 mm)	1.66
Grade III/Marked (15 mm or more)	2.5
Ligamentous Laxity of Ankle	
Medial or Lateral	2

E. Osteoarthritis

1. General

The following principles apply to assessment of osteoarthritis in a lower extremity weight bearing joint generally:

- Osteoarthritis is classified as mild, moderate, moderately severe or severe based on imaging studies and/or operative reports.

- The available disability rating for osteoarthritis is compared to the total of the available disability ratings for loss of range of motion and loss of strength in the affected limb, and the higher of the two is provided. That percentage is then added to any percentage of disability rated for ligamentous laxity of the limb.

Note that osteoarthritis is only considered to result in a disability where it occurs in a lower extremity weight bearing joint. Osteoarthritis in other joints is not considered to result in a disability.

2. Osteoarthritis in the Hip, Ankle or Foot

Osteoarthritis in the hip, ankle or foot is rated using the following table:

Class of Osteoarthritis	Grade of Chondromalacia	Percentage of Arthrodesis Value
Mild	0 (normal) and 1 (softening of cartilage)	0
Moderate	2 (fibrillation of cartilage)	10
Moderately Severe	3 (ulceration of cartilage)	20
Severe (full thickness cartilage loss)	4 (bone showing through)	30

3. Osteoarthritis in the Knee

The following additional principles apply to assessment of disability from osteoarthritis in the knee specifically:

- Osteoarthritis may exist in multiple compartments of the knee: the medial compartment, the lateral compartment and/or the patellofemoral compartment.

- Disability from osteoarthritis in the knee is assessed based on the compartment that results in the highest disability rating (not necessarily the compartment with the most severe class of osteoarthritis). Multiple ratings for osteoarthritis in multiple compartments of the knee are not added. Only the rating of the compartment that results in the highest disability rating is used.

- For example, if a worker has severe osteoarthritis of the patellofemoral joint (assessed at 3% total disability) and moderately severe osteoarthritis of the medial compartment (assessed at 5% of total disability), the worker's disability rating for osteoarthritis in the knee would be 5% of total disability.

Osteoarthritis in the knee is assessed using the following table:

Class of Osteoarthritis	**Grade of Chondromalacia**	**Percentage (of Total Disability)**		
		Medial Compartment	**Lateral Compartment**	**Patellofemoral Compartment**
Mild	0 (normal) and 1 (softening of cartilage)	0	0	0
Moderate	2 (fibrillation of cartilage)	2.5	2.5	1
Moderately Severe	3 (ulceration of cartilage)	5	5	2
Severe (full thickness cartilage loss)	4 (bone showing through)	7.5	7.5	3

F. Partial Loss of Range Of Motion

Partial loss of range of motion in the lower extremity is proportional to the amount of movement lost, applied to the complete immobility rating:

$$\frac{loss\ of\ range\ of\ motion}{normal\ range\ of\ motion} \times immobility\ rating\ = loss\ of\ range\ of\ motion\ rating$$

The following principles apply when rating partial loss of range of motion in a lower extremity:

- A loss of range of motion of five degrees or less generally does not impair a worker's earning capacity to an ascertainable degree.
- When assessing loss of range of motion in a lower extremity, there is usually a normal side for comparison. In instances when a normal side does not exist, reference is made to the normal range of motion values set out below.
- Loss of hyperextension in an unusually flexible worker does not result in a disability. The loss of range of motion in the injured extremity of an unusually flexible worker would be compared with the normal range of motion values set out below.

Lower Extremity Normal Range of Motion Values

	Degrees
Hip	
Flexion	113
Extension	28
Abduction	48
Adduction	31
Internal Rotation	30
External Rotation	45
Knee	
Flexion	134
Extension	0
Ankle	
Dorsiflexion	18
Plantar Flexion	40

Great Toe

IPJ	Flexion	60
	Extension	0
MPJ	Flexion (Plantar Flexion)	37
	Extension (Dorsi Flexion)	63

Fraction of full movement

Midtarsal .....¼, ½, ¾ or full

Subtalar .....¼, ½, ¾ or full

G. Loss of Strength

This section sets out how to rate loss of strength where loss of strength is the only permanent impairment in the lower extremity or when a loss of strength is rated separately and added to other ratings in the Schedule.

In cases where loss of strength is rated separately and added to other ratings in the Schedule, the loss of strength is rated using the Medical Research Council (MRC) Scale. The MRC Scale is a numerical rating scale used to assess muscle power on a scale from 0 (no contraction) to 5 (normal power) in relation to the maximum expected for the muscle being tested.

To determine when loss of strength is rated separately and added to other ratings in the Schedule, see Section II, “Application of the Schedule”, under heading F. Loss of Strength.

Loss of strength in the lower extremity is assessed per leg. Such a disability rating is only to be applied if there is strong, consistent, objective evidence of loss of strength. In addition, there must be a clear pathological explanation for the weakness.

Loss of strength in the lower extremity is assessed as follows:

MRC Scale	Definition	PDES Percentage
5	Normal power	0
4+	Active movement against gravity and strong resistance	1
4	Active movement against gravity and moderate resistance	2
4-	Active movement against gravity and slight resistance	3
3	Movement possible against gravity, but not against added resistance	5
2	Movement possible, but not against gravity (test joint in its horizontal plane)	7
1	Flicker or trace of contraction, but no movement	7
0	No contraction	7

H. Deformity

Percentage

Recurvatum, greater than 10 degrees for each limb 2

Valgus, greater than 10 degrees for each limb 2

Varus, greater than 10 degrees for each limb 2

Rotation, greater than 10 degrees for each limb 2

The rating for valgus and/or varus angulation of the knee may be added to the rating for osteoarthritis only if the deformity was caused by something other than the osteoarthritis, for example a knee injury. If the angulation is deemed to be due to the osteoarthritis, then it is taken into consideration as part of the osteoarthritis disability rating.

I. Miscellaneous Conditions and Surgical Procedures

Unless otherwise specified, disability ratings for miscellaneous conditions and surgical procedures involving the lower extremity are added to the other applicable ratings for immobility, shortening causing a difference in leg length, ligamentous laxity, osteoarthritis, loss of range of motion, loss of strength and/or loss of sensation in the affected extremity.

Active septic arthritis or pseudarthrosis is rated as 25% of arthrodesis value of the joint, in addition to any percentage provided for loss of range of motion.

Loss of an ankle reflex does not constitute disability if it is not accompanied by any other functional deficit.

Resurfacing or partial arthroplasties merit the same disability rating as a complete arthroplasty.

VI. Lower Extremity

	Percentage
Total Hip Prosthesis (including Femoral Head Prosthesis)	6
Total Knee Prosthesis or Hemiarthroplasty	9
Total Ankle Prosthesis/Complete Ankle Replacement	5
Comminuted Calcaneal Fractures	7
Patellectomy	
Partial	3
Total	6

Note: Section XI, “Central Nervous System Conditions”, under heading F. Stance and Gait, provides guidance on rating disability associated with stance and gait disturbances. Ratings under that heading are only to be applied if there is no other way of assessing the worker’s lower extremity disability provided in the Schedule (e.g. based on amputation value, loss of strength, loss of range of motion, sensory loss, weakness, etc.).

VII. Pelvis

Compensable conditions of the pelvis include healed fractures, with or without displacement.

	Percentage
Single ramus	0
Bilateral rami	0
Unilateral superior and inferior rami	0
Ilium	0
Ischium, displaced 2.5 cm or more	10
Symphysis pubis, displaced or separated:	
With displacement of less than 2 cm	0 – 3.5
With displacement of 2 cm or more	0 – 5.5
Sacrum, into sacroiliac joint	3.5
Coccyx, non-union or resection	2

Fracture into acetabulum – evaluate on basis of restricted motion of hip joint.

All fractures of the pelvis are likely to cause reduced range of motion, loss of strength and/or sensory loss. The above fracture values include consideration of such consequent loss of function.

However, if a worker has marked loss of function which would entitle the worker to a higher disability rating than the fracture value, based solely on loss of range of motion, loss of strength and/or sensory loss, the greater of the two values would be provided.

VIII. Peripheral Nervous System Conditions

A. Criteria for Assessing Loss of Peripheral Nerve Function

The criteria for assessing loss of peripheral nerve function are as follows:

1. Sensory

Normal	No loss of function
Mild	Slight paresthesia/hypesthesia (or allodynia/hyperesthesia/dysesthesia)
Moderate	Moderate paresthesia/hypesthesia (or allodynia/hyperesthesia/dysesthesia)
Marked	As above (moderate) + loss of stereognosis + ulcers/trophic changes or marked paresthesia/hypesthesia (or allodynia/hyperesthesia/dysesthesia)
Complete	No sensation

2. Motor

MRC Scale	Definition
5	Normal power
4+	Active movement against gravity and strong resistance
4	Active movement against gravity and moderate resistance
4-	Active movement against gravity and slight resistance
3	Movement possible against gravity, but not against added resistance
2	Movement possible, but not against gravity (test joint in its horizontal plane)
1	Flicker or trace of contraction, but no movement
0	No contraction

A disability rating for loss of motor nerve function is assessed using the Medical Research Council (MRC) Scale. The MRC Scale is a numerical rating scale used to assess muscle power on a scale from 0 (no contraction) to 5 (normal power) in relation to the maximum expected for the muscle being tested.

VIII. Peripheral Nervous System Conditions

A disability rating for loss of peripheral nerve function includes consideration of consequent loss of range of motion unless there is an additional mechanical, anatomical or other underlying pathological reason for limitation of these functions.

Note: A disability rating for loss of peripheral function includes consideration of consequent loss of strength. See Section II, “Application of the Schedule”, under heading F. Loss of Strength to determine when loss of strength is rated separately and added to other ratings in the Schedule.

B. Table of Ratings for Peripheral Nerve Conditions

(Values listed in this table are percentages of total disability)

The full values in each of the grades listed in the table below will be provided for sensory and/or motor loss affecting the whole or partial distribution of the nerve.

1. Sensory

		Sensory
Long Thoracic Nerve		
	Normal	n/a
	Mild	n/a
	Moderate	n/a
	Marked	n/a
	Complete	n/a
Median Nerve		
At elbow	Normal	0
	Mild	5
	Moderate	10
	Marked	15
	Complete	20
At wrist	Normal	0
	Mild	3
	Moderate	6
	Marked	9
	Complete	12
Ulnar Nerve		
At elbow	Normal	0
	Mild	0.75
	Moderate	1.5
	Marked	2.25
	Complete	3

		Sensory
At wrist	Normal	0
	Mild	0.6
	Moderate	1.2
	Marked	1.8
	Complete	2.4
Radial Nerve		
	Normal	0
	Mild	0.5
	Moderate	1
	Marked	1.5
	Complete	2
Axillary Nerve		
	Normal	0
	Mild	0.15
	Moderate	0.3
	Marked	0.45
	Complete	0.6
Lateral Cutaneous Nerve of the Forearm		
	Normal	0
	Mild	0.5
	Moderate	1
	Marked	1.5
	Complete	2
Medial Cutaneous Nerve of the Forearm		
	Normal	0
	Mild	0.5
	Moderate	1
	Marked	1.5
	Complete	2
Musculocutaneous Nerve of the Brachial Plexus		
	Normal	0
	Mild	.5
	Moderate	1
	Marked	1.5
	Complete	2
Sciatic Nerve		
	Normal	0
	Mild	3

		Sensory
	Moderate	6
	Marked	9
	Complete	12

Femoral Nerve

	Normal	0
	Mild	0.625
	Moderate	1.25
	Marked	1.875
	Complete	2.5

Obturator Nerve

	Normal	0
	Mild	0.625
	Moderate	1.25
	Marked	1.875
	Complete	2.5

Saphenous Nerve

	Normal	0
	Mild	1
	Moderate	2
	Marked	3
	Complete	4

Common Peroneal Nerve (Lateral Popliteal)

	Normal	0
	Mild	1
	Moderate	2
	Marked	3
	Complete	4

Deep Peroneal Nerve (Anterior Tibial)

	Normal	0
	Mild	0.2
	Moderate	0.3
	Marked	0.4
	Complete	0.5

Superficial Peroneal Nerve (Musculocutaneous)

	Normal	0
	Mild	0.4
	Moderate	0.6
	Marked	0.8
	Complete	1

		Sensory
Tibial Nerve (Posterior Tibial or Medial Popliteal)		
	Normal	0
	Mild	2
	Moderate	4
	Marked	6
	Complete	8
Sural Nerve		
	Normal	0
	Mild	0.5
	Moderate	1
	Marked	1.5
	Complete	2.0
Lateral Femoral Cutaneous Nerve (Lateral Cutaneous Nerve of the Thigh)		
	Normal	0
	Mild	0.5
	Moderate	1
	Marked	1.5
	Complete	2.0
Posterior Cutaneous Nerve of the Thigh		
	Normal	0
	Mild	0.5
	Moderate	1.0
	Marked	1.5
	Complete	2.0

2. Motor

	MRC Scale	**Motor**
Long Thoracic Nerve		
	5	0
	4+	2
	4	2.5
	4-	3
	3	4
	2	5
	1	5
	0	5
Median Nerve		
At elbow	5	0

	MRC Scale	Motor
	4+	5
	4	7.5
	4-	10
	3	15
	2	20
	1	20
	0	20
At wrist	5	0
	4+	2
	4	3
	4-	4
	3	6
	2	8
	1	8
	0	8
Ulnar Nerve		
At elbow	5	0
	4+	3
	4	4.5
	4-	6
	3	10
	2	16
	1	16
	0	16
At wrist	5	0
	4+	2
	4	3
	4-	4
	3	8
	2	10
	1	10
	0	10
Radial Nerve		
	5	0
	4+	4.5
	4	6.75
	4-	9
	3	13.5
	2	18
	1	18

MRC Scale	Motor
0	18
Axillary Nerve	
5	0
4+	1.35
4	2.03
4-	2.7
3	4.05
2	5.4
1	5.4
0	5.4
Lateral Cutaneous Nerve of the Forearm	
n/a	n/a
Medial Cutaneous Nerve of the Forearm	
n/a	n/a
Musculocutaneous Nerve of the Brachial Plexus	
5	0
4+	4.5
4	6.75
4-	9
3	13.5
2	18
1	18
0	18
Sciatic Nerve	
5	0
4+	4.5
4	6.75
4-	9
3	13.5
2	18
1	18
0	18
Femoral Nerve	
5	0
4+	2.5
4	3.75
4-	5
3	7.5
2	10

MRC Scale	Motor
1	10
0	10

Obturator Nerve

5	0
4+	2.5
4	3.75
4-	5
3	7.5
2	10
1	10
0	10

Saphenous Nerve

n/a	n/a

Common Peroneal Nerve (Lateral Popliteal)

5	0
4+	5
4	7.5
4-	10
3	15
2	20
1	20
0	20

Deep Peroneal Nerve (Anterior Tibial)

5	0
4+	2.5
4	3.75
4-	5
3	10
2	15
1	15
0	15

Superficial Peroneal Nerve (Musculocutaneous)

5	0
4+	0.5
4	0.75
4-	1
3	2
2	2.5
1	2.5
0	2.5

	MRC Scale	Motor
Tibial Nerve (Posterior Tibial or Medial Popliteal)		
	5	0
	4+	3
	4	4.5
	4-	6
	3	9
	2	12
	1	12
	0	12
Sural Nerve		
	n/a	n/a
Lateral Femoral Cutaneous Nerve (Lateral Cutaneous Nerve of the Thigh)		
	n/a	n/a
Posterior Cutaneous Nerve of the Thigh	n/a	n/a

Infraorbital nerve sensory loss is rated at 1% of total disability.

Genitofemoral nerve injury – loss of cremasteric reflex. Loss of the cremasteric reflex does not constitute disability.

IX. Nerve Root Conditions

A. Criteria for Assessing Loss of Nerve Root Function

The criteria for assessing loss of nerve root function are as follows:

1. Sensory

Normal	No loss of function
Mild	Slight paresthesia/hypesthesia (or allodynia/hyperesthesia/dysesthesia
Moderate	Moderate paresthesia/hypesthesia (or allodynia/hyperesthesia/dysesthesia)
Marked	As above (moderate) + loss of stereognosis + ulcers/trophic changes or marked paresthesia/hypesthesia (or allodynia/hyperesthesia/dysesthesia
Complete	No sensation

2. Motor

MRC Scale	Definition
5	Normal power
4+	Active movement against gravity and strong resistance
4	Active movement against gravity and moderate resistance
4-	Active movement against gravity and slight resistance
3	Movement possible against gravity, but not against added resistance
2	Movement possible, but not against gravity (test joint in its horizontal plane)
1	Flicker or trace of contraction, but no movement
0	No contraction

A disability rating for loss of nerve root function includes consideration of consequent loss of range of motion unless there is an additional mechanical, anatomical or other underlying pathological reason for limitation of these functions.

A disability rating for loss of motor nerve function is assessed using the Medical Research Council (MRC) Scale. The MRC Scale is a numerical rating scale used

to assess muscle power on a scale from 0 (no contraction) to 5 (normal power) in relation to the maximum expected for the muscle being tested.

Note: A disability rating for loss of nerve root function includes consideration of consequent loss of strength. See Section II, “Application of the Schedule”, under heading F. Loss of Strength to determine when loss of strength is rated separately and added to other ratings in the Schedule.

B. Table of Ratings for Nerve Root Conditions

(Values listed in this table are percentages of total disability)

The C4 spinal level is considered on a case-by-case basis for both sensory and motor loss.

The full values in each of the grades listed in the table below will be provided for sensory and/or motor loss affecting the whole or partial distribution of the nerve.

Each nerve root within a grouped spinal level (i.e., T3 through T12 and S2 through S5) has an individual disability rating and is calculated separately. Each nerve root is assessed, however a disability rating is provided only if the nerve root is affected.

1. Sensory

Nerve Root		Sensory
C5	Normal	0
	Mild	1
	Moderate	2
	Marked	3
	Complete	4
C6		
	Normal	0
	Mild	1.5
	Moderate	3
	Marked	4.5
	Complete	6
C7	Normal	0
	Mild	1
	Moderate	2
	Marked	3
	Complete	4

IX. Nerve Root Conditions

Nerve Root		Sensory
C8	Normal	0
	Mild	1
	Moderate	2
	Marked	3
	Complete	4
T1	Normal	0
	Mild	0.5
	Moderate	1
	Marked	1.5
	Complete	2
T2	Normal	0
	Mild	0.5
	Moderate	1
	Marked	1.5
	Complete	2
T3 through T12	Normal	0
	Mild	0.125
	Moderate	0.25
	Marked	0.375
	Complete	0.5
L1	Normal	0
	Mild	1
	Moderate	2
	Marked	3
	Complete	4
L2	Normal	0
	Mild	1
	Moderate	2
	Marked	3
	Complete	4
L3	Normal	0
	Mild	1
	Moderate	2
	Marked	3
	Complete	4

Nerve Root		Sensory
L4	Normal	0
	Mild	1
	Moderate	2
	Marked	3
	Complete	4
L5	Normal	0
	Mild	1
	Moderate	2
	Marked	3
	Complete	4
S1	Normal	0
	Mild	1.5
	Moderate	3
	Marked	4.5
	Complete	6
S2 through S5*	Normal	0
	Mild	0.5
	Moderate	1
	Marked	1.5
	Complete	2

*any related rating for urological or sexual dysfunction would be added to the sensory loss rating, which are covered under Section XI (Central Nervous System Conditions), subsection E (Neurological Sexual Conditions).

2. Motor

Nerve Root	MRC Scale	Motor
C5	5	0
	4+	4
	4	6
	4-	8
	3	12
	2	16
	1	16
	0	16

IX. Nerve Root Conditions

Nerve Root	MRC Scale	Motor
C6	5	0
	4+	4.5
	4	6.75
	4-	9
	3	13.5
	2	18
	1	18
	0	18
C7	5	0
	4+	5
	4	7.5
	4-	10
	3	15
	2	20
	1	20
	0	20
C8	5	0
	4+	6
	4	8
	4-	12
	3	18
	2	24
	1	24
	0	24
T1	5	0
	4+	3
	4	4.5
	4-	6
	3	10
	2	14
	1	14
	0	14
T2	n/a	n/a
T3 through T12	n/a	n/a

IX. Nerve Root Conditions

Nerve Root	MRC Scale	Motor
L1	5	0
	4+	3
	4	4.5
	4-	6
	3	9
	2	12
	1	12
	0	12
L2	5	0
	4+	3
	4	4.5
	4-	6
	3	9
	2	12
	1	12
	0	12
L3	5	0
	4+	3
	4	4.5
	4-	6
	3	9
	2	12
	1	12
	0	12
L4	5	0
	4+	3
	4	4.5
	4-	6
	3	9
	2	12
	1	12
	0	12
L5	5	0
	4+	5
	4	7.5
	4-	10
	3	15
	2	20
	1	20
	0	20

Nerve Root	MRC Scale	Motor
S1	5	0
	4+	3
	4	4.5
	4-	6
	3	9
	2	12
	1	12
	0	12
S2 through S5*	n/a	n/a

C. Autonomic Dysfunction

	Percentage
Horner's Syndrome	2

X. Spine

A. General

The following principles apply to assessment of disability in the spine:

- Anatomical loss or damage resulting from injury or surgery may contribute to physical disability of the spine. When anatomic and/or surgical disability is present as well as loss of range of motion of the spine, the final disability rating is based on the greater of the two.
- Range of motion of the spine is difficult to assess on a consistent basis because the joints of the spine are small, inaccessible and not externally visible.
- Only movement of a region of the spine can be measured; it is not possible to measure mobility of a single vertebra.
- A loss of range of motion in the spine of three degrees or less generally does not impair a worker's earning capacity to an ascertainable degree.

Total paraplegia is rated as 100% of total disability.

Total quadriplegia is rated as 100% of total disability.

A vertebrectomy merits a rating equivalent to the rating for a two-level fusion, plus the maximum rating available if the removed vertebra has a compression fracture with over 50% compression.

B. Cervical Spine

	Percentage
Compression fractures	
Up to 50% compression	0 – 2
Over 50% compression	2 – 4
Impairment resulting from surgical loss of intervertebral disc C1 to D1	2 per level
Ankylosis (fusion) C1 to D1 including surgical loss of intervertebral disc	3 per level
C1 Jefferson Fracture	2
Loss of range of motion	
Flexion	0 – 6
Extension	0 – 3

Lateral flexion right and left ..... each 0 – 2

Rotation right and left ..... each 0 – 4

Maximum disability rating for cervical spine not to exceed 21

C. Thoracic Spine

Percentage

Compression fractures

Up to 50% compression ..... 0 – 1

Over 50% compression ..... 1 – 2

Impairment resulting from surgical loss of intervertebral disc D1 to D12 ..... 1 per level to a max of 6

Ankylosis (fusion) D1 to D12 including surgical loss of intervertebral disc ..... 1 per level to a max of 6

Loss of Range of Motion Rotation, Right and Left, Each ..... 0 – 3

Maximum disability rating for thoracic spine not to exceed 6

D. Lumbar Spine

Percentage

Compression fractures to include D12

Up to 50% compression ..... 0 – 2

Over 50% compression ..... 2 – 4

Impairment resulting from surgical loss of intervertebral disc D12 to S1 ..... 2 per level

Ankylosis (fusion) D12 to S1 including surgical loss of intervertebral disc ..... 4 per level

Loss of range of motion

Flexion ..... 0 – 9

Extension ..... 0 – 5

Lateral flexion, right and left ..... each 0 – 5

Maximum disability rating for lumbar spine not to exceed 24

E. Spine Normal Range of Motion Values

	Degrees
Cervical Spine	
Flexion	40
Extension	40
Lateral Flexion	30
Rotation	60
Thoracic Spine	
Rotation	45
Lumbar Spine	
Flexion	60
Extension	25
Lateral Flexion	25

XI. Central Nervous System Conditions

A. Seizure Disorder/Episodic Loss of Consciousness

Percentage

Grade 1 Paroxysmal disorder with predictable characteristics and unpredictable occurrence that does not limit usual activities but is a risk to the individuals or limits daily activities ..... 0 – 14

Grade 2 Paroxysmal disorder that interferes with some daily activities ..... 15 – 29

Grade 3 Severe paroxysmal disorder of such frequency that it limits activities to those that are supervised, protected or restricted

AND

Additional neurologic symptoms or signs of focal or generalized nature ..... 30 – 49

Grade 4 Uncontrolled paroxysmal disorder of such severity and constancy that it severely limits the individual's daily activities ..... 50 – 70

B. Cranial Nerves

Percentage

Cranial nerve I (olfactory) anosmia 3

Cranial nerve II – See Section XII of the Schedule, "Vision Disability", regarding visual acuity and visual field assessment

Cranial nerve III, IV & VI (optic, oculomotor, trochlear, and abducens nerves) – See Section XII of the Schedule, "Vision Disability", regarding diplopia, mydriasis and myosis

Cranial nerve V (trigeminal nerve)

Unilateral sensory loss ..... 0 – 10

Unilateral motor loss ..... 0 – 5

Cranial nerve VII (facial nerve)

		Percentage
Grade 1	Complete loss of taste on anterior tongue and/or mild unilateral facial weakness	0 – 4
Grade 2	Mild to moderate bilateral facial weakness and/or severe unilateral facial paralysis with 75% or greater facial involvement and with inability to control eyelid closure	5 – 19
Grade 3	Severe bilateral facial paralysis with 75% or greater facial involvement and with inability to control eyelid closure	20 – 45

Cranial nerve VIII – See Sections XIII, “Traumatic Hearing Loss”, XIV, “Non-Traumatic Hearing Loss (Schedule 2/Section 145 of the *Act*)”, and XV, “Ear Nose and Throat Conditions”.

Cranial nerves IX, X and XII (glossopharyngeal, vagus and hypoglossal nerves)

Grade 1	Mild dysarthria, dystonia, or dysphagia with choking on liquids or semisolid food	0 − 14
Grade 2	Moderately severe dysarthria or dysphagia with hoarseness, nasal regurgitation, and aspiration of liquids or semisolid foods	15 − 39
Grade 3	Severe inability to swallow or handle oral secretions without choking, with need for assistance and suctioning	40 – 60

Cranial nerve XI (spinal accessory nerve), complete paralysis of:

Sternocleidomastoid	
Unilateral	3
Bilateral	7.5
Trapezius	
Unilateral	5
Bilateral	12.5

C. Neurological Urinary Bladder Control

		Percentage
Grade 1	Individual has some degree of voluntary control but is impaired by urgency or intermittent incontinence	0 − 9
Grade 2	Individual has good bladder reflex activity limited capacity, and intermittent emptying without voluntary control	10 − 24
Grade 3	Individual has poor bladder reflex activity intermittent dribbling, and no voluntary control	25 − 39
Grade 4	Individual has no reflex or voluntary control of bladder	40 – 60

D. Neurological Anorectal Conditions

		Percentage
Grade 1	Individual has reflex regulation but only limited voluntary control	0 − 19
Grade 2	Individual has reflex regulation but no voluntary control	20 − 39
Grade 3	Individual has no reflex regulation or voluntary control	40 – 50

E. Neurological Sexual Conditions

Note that any related rating for urological or sexual dysfunction would be added to the sensory loss rating for S2 through S5.

		Percentage
Grade 1	Sexual functioning is possible, but with varying degrees of difficulty with erection or ejaculation in men, or lack of awareness, excitement, or lubrication in either sex	0 − 9
Grade 2	Reflex sexual functioning is possible, but there is no awareness	10 − 19
Grade 3	No sexual functioning is possible	20

F. Stance and Gait

The table below was designed to be used to rate disability associated with neurological conditions causing stance and gait disturbances that are too complex to assess by other parameters. However, it may also be used to rate disability associated with non-neurological conditions that result in stance and gait disturbances that are so complex that other means of assessment are impractical.

A disability rating specifically for stance and gait is only to be applied if there is no other way of assessing a worker's lower extremity disability provided in the Schedule (e.g. based on amputation value, loss of strength, loss of range of motion, sensory loss, weakness, etc.). Disability ratings specifically for stance and gait are not to be added to any other lower extremity disability ratings.

Disability specifically for stance and gait is assessed as follows:

		Percentage
Grade 1	Rises to standing position; walks, but has difficulty with elevations, grades, stairs, deep chairs, and long distances	0 − 9
Grade 2	Rises to standing position; walks some distance with difficulty and without assistance, but is limited to level surfaces	10 − 19
Grade 3	Rises and maintains standing position with difficulty; cannot walk without assistance	20 − 39
Grade 4	Cannot stand without help, mechanical support, and/or an assistive device	40 – 60

G. Impairments of the Upper Extremities

The tables below were designed to be used to rate disability associated with neurological conditions causing upper extremity impairments that are too complex to assess by other parameters. However, it may also be used to rate disability associated with non-neurological conditions that result in upper extremity impairments that are so complex that other means of assessment are impractical.

A disability rating specifically for impairments of the upper extremities is only to be applied if there is no other way of assessing a worker's upper extremity disability provided in the Schedule (e.g. based on amputation value, loss of strength, loss of range of motion, sensory loss, weakness, etc.). Disability ratings specifically for upper extremities are not to be added to any other upper extremity disability ratings.

Disability specifically for the upper extremities are assessed as follows:

Impairment of one upper extremity:

		Percentage
Grade 1	Individual can use the involved extremity for self-care, daily activities, and holding, but has difficulty with digital dexterity	1 – 9
Grade 2	Individual can use the involved extremity for self-care, can grasp and hold objects with difficulty, but has no digital dexterity	10 – 24
Grade 3	Individual can use the involved extremity, but has difficulty with self-care activities	25 – 39
Grade 4	Individual cannot use the involved extremity for self-care or daily activities	40 – 60

Impairment of both upper extremities:

		Percentage
Grade 1	Individual can use both upper extremities for grasping, and holding, but has difficulty with digital dexterity	1 – 19
Grade 2	Individual can use both upper extremities for self-care, can grasp and hold objects with difficulty, but has no digital dexterity	20 – 39
Grade 3	Individual can use both upper extremities, but has difficulty with self-care activities	40 – 79
Grade 4	Individual cannot use upper extremities	80+

XII. Vision Disability

The maximum rating for vision disability in both eyes is 100% of total disability. The maximum rating for vision disability in one eye is 16% of total disability, except in the case of enucleation or evisceration of one eye, for which a rating of 18% of total disability applies.

To assess vision disability, first evaluate disability involving the primary visual system by assessing loss of visual acuity and loss of visual field, and then making any necessary adjustments for the impact of other visual disturbances. An additional rating may also be added for disability resulting from secondary ocular conditions, subject to the maximum ratings for vision disability set out above.

A. Primary Visual System Conditions

1. Loss of Visual Acuity

Visual acuity describes the ability of the eye to perceive details in the environment. Loss of visual acuity is based on best vision obtainable after correction.

a. Loss of Visual Acuity - One Eye

Blindness or complete loss of vision in one eye is equal to a best corrected visual acuity of 20/200 or worse.

Best Corrected Visual Acuity		Percentage
Feet	**Meters**	
20/20	6/6	0
20/25	6/7.5	0
20/30	6/9	0
20/40	6/12	1
20/50	6/15	2
20/60	6/18	4
20/70	6/21	5
20/80	6/24	6
20/100	6/30	8
20/150	6/45	12
20/200	6/60	16
20/400	6/120	16

b. Loss of Visual Acuity - Two Eyes

As total blindness in one eye is assessed at 16% of total disability and total blindness in two eyes is equal to 100% of total disability, the value attached to total loss of visual acuity in the second eye is 84%. When assessing a bilateral

loss of visual acuity, each eye is first assessed separately and then their values are combined in accordance with the following chart:

	20/30	20/40	20/50	20/60	20/70	20/80	20/100	20/150	20/200
20/30	0.0	1.0	2.0	4.0	5.0	6.0	8.0	12.0	16.0
20/40	1.0	6.3	7.3	9.3	10.3	11.3	13.3	17.3	21.3
20/50	2.0	7.3	12.5	14.5	15.5	16.5	18.5	22.5	26.5
20/60	4.0	9.3	14.5	25.0	26.0	27.0	29.0	33.0	37.0
20/70	5.0	10.3	15.5	26.0	31.3	32.3	34.3	38.3	42.3
20/80	6.0	11.3	16.5	27.0	32.3	37.5	39.5	43.5	47.5
20/100	8.0	13.3	18.5	29.0	34.3	39.5	50.0	54.0	58.0
20/150	12.0	17.3	22.5	33.0	38.3	43.5	54.0	75.0	79.0
20/200	16.0	21.3	26.5	37.0	42.3	47.5	58.0	79.0	100.0

These ratings are derived from the formula:

$$Combined\ rating = ({}^{84}/_{16} \times rating\ of\ better\ eye) + rating\ of\ poorer\ eye$$

For example: If the best corrected visual acuity in the right eye is 20/50 (2% disability) and in the left eye is 20/100 (8% disability), the resultant disability is $({}^{84}/_{16}$ x 2%) + 8% = 18.5%.

2. Loss of Visual Field

Visual field refers to the total area in which objects can be seen when the eye focuses on a fixed point. Loss of visual field is based on best vision obtainable after correction.

a. Loss of Visual Field − One Eye

Blindness or complete loss of vision in one eye is equal to a best corrected visual field of 0.

Visual Field Score	Percentage
100	0
90	0
80	1
70	2
60	4
50	5
40	6
30	8
20	12
10	16
0	16

The visual field score is derived from converting the results of a visual field test using one or more of the overlay grids for *Humphrey* visual field plots.

b. Loss of Visual Field – Two Eyes

As total blindness in one eye is assessed at 16% and total blindness in two eyes is equal to 100% of total disability, the value attached to total loss of visual field in the second eye is 84%. When assessing a bilateral loss of visual field, each eye is first assessed separately and then their values are combined in accordance with the following chart:

	100	90	80	70	60	50	40	30	20	10	0
100	0	0	1	2	4	5	6	8	12	16	16
90	0	0	1	2	4	5	6	8	12	16	16
80	1	1	6.25	7.25	9.25	10.25	11.25	13.25	17.25	21.25	21.25
70	2	2	7.25	12.5	14.5	15.5	16.5	18.5	22.5	26.5	26.5
60	4	4	9.25	14.5	25	26	27	29	33	37	37
50	5	5	10.25	15.5	26	31.25	32.25	34.25	38.25	42.25	42.25
40	6	6	11.25	16.5	27	32.25	37.5	39.5	43.5	47.5	47.5
30	8	8	13.25	18.5	29	34.25	39.5	50	54	58	58
20	12	12	17.25	22.5	33	38.25	43.5	54	75	79	79
10	16	16	21.25	26.5	37	42.25	47.5	58	79	100	100
0	16	16	21.25	26.5	37	42.25	47.5	58	79	100	100

These ratings are derived from the formula:

$$Combined\ rating = ({}^{84}/_{16} \times rating\ of\ better\ eye) + rating\ of\ poorer\ eye$$

For example: If the best corrected visual field in the right eye is 50 (5% disability) and in the left eye is 70 (2% disability), the resultant disability is $({}^{84}/_{16}$ x 2%) + 5% = 15.5%.

3. Other Visual Disturbances

a. Photophobia

Percentage

Mild — Photophobia is present, and the worker experiences discomfort when exposed to light

AND

Symptoms are eliminated with the use of sunglasses, a hat, or a sun shade 1

Moderate — Photophobia is present, and the worker experiences discomfort when exposed to light

AND

	Symptoms are present with the use of sunglasses, a hat, or a sun shade resulting in no or slight limitation of ability to perform routine daily activities.....	3
Severe	Photophobia is present, and the worker experiences discomfort when exposed to light AND Symptoms are present with the use of sunglasses, a hat, or a sun shade resulting in inability, or marked limitation of ability to perform routine daily activities (e.g. the individual is unable to drive).....	8

b. Loss of Accommodation

Loss of accommodation is based on the worker's age at the time of injury *except* when a cataract develops, in which case it is based on the worker's age at the time of the cataract extraction. In all cases it is not adjusted (reduced) for subsequent aging. In the case of a worker having a presbyopic or accommodating implant inserted at the time of cataract surgery, no age adjusted loss of accommodation would apply.

Age Adjusted Loss of Accommodation

Age	Percentage
0 − 40	6
41 − 45	5
46 − 50	4
51 − 55	3
56 − 60	2
>60	0

c. Diplopia

Diplopia that is permanent and not correctable with prisms, lenses or surgery is assessed as:

		Percentage
Mild	Field of Binocular Single Vision > 30 degrees	1

Moderate	Field of Binocular Single Vision 21-30 degrees	2 – 9
Severe	Field of Binocular Single Vision 11-20 degrees	10 – 15
Very Severe	Field of Binocular Single Vision 0-10 degrees	16

d. Aniseikonia

Severe aniseikonia that cannot be corrected may result in the loss of binocularity and may be assessed in the range of 0 - 8% of total disability.

B. Secondary Ocular Conditions

Secondary ocular conditions may cause permanent disability in addition to disability associated with primary visual system conditions. Therefore, ratings for secondary ocular conditions may be added to any applicable rating for the primary visual system, subject to the maximum ratings for vision disability set out above.

Percentage

Glaucoma 2

Complete Loss of Iris 4

Partial Loss of Iris ..... 0 – 4

Fixed Mydriasis 2

Fixed Miosis 1

Dry eyes needing artificial tears or other treatment 2

Tearing due to lacrimal duct obstruction

- Mild 1
- Moderate 2
- Severe 3

Cataracts, aphakia, double aphakia and pseudoaphakia/pseudophakia are assessed by their resultant changes in visual acuity and age-related loss of accommodation.

XIII. Traumatic Hearing Loss

Percentage

Complete hearing loss in one ear with no loss in the other..... 6

Complete hearing loss in both ears..... 36

A. Unilateral Traumatic Hearing Loss

Difference in hearing loss in decibels (dB) measured in affected ear (ANSI)	Percentage
20 – 29	2
30 – 39	4
40 or more	6

The hearing loss due to the compensable condition expressed in dB in the first column is the difference in the arithmetic average of thresholds of hearing measured in each ear in turn by pure-tone air- or bone-conduction audiometry at frequencies of 500, 1,000, 2,000 and 3,000 Hz.

B. Bilateral Traumatic Hearing Loss

Hearing loss in decibels (dB) measured in each ear in turn (ANSI)	Percentage		
	ear most affected	PLUS	ear least affected
35 – 39	0.3		1.5
40 – 44	1.0		5.0
45 – 49	1.7		8.5
50 – 54	2.3		11.5
55 – 59	3.0		15.0
60 – 64	3.7		18.5
65 – 69	4.3		21.5
70 – 74	5.0		25.0
75 – 79	5.7		28.5
80 or more	6.0		30.0

The hearing loss due to the compensable condition expressed in dB in the first column is the arithmetic average of thresholds of hearing measured in each ear in turn by pure-tone air- or bone-conduction audiometry at frequencies of 500, 1,000, 2,000 and 3,000 Hz.

After a worker's bilateral traumatic hearing loss is assessed, a deduction of 0.5 decibels is made for each year the worker's age exceeds 50 to allow for presbycusis (age-related hearing loss), effective the date of the permanent disability benefits. This is done for each ear.

XIV. Non-Traumatic Hearing Loss (Schedule 2/Section 145 of the *Act*)

Percentage

Complete hearing loss in one ear with no loss in the other..... 6

Complete hearing loss in both ears..... 36

Item	Column 1 **Range of Hearing Loss (decibels)**	Column 2 **Percentage of Disability for Ear Most Affected**	Column 3 **Percentage of Disability for Ear Least Affected**
1	0-34	0	0
2	35-39	0.3	1.5
3	40-44	1.0	5.0
4	45-49	1.7	8.5
5	50-54	2.3	11.5
6	55-59	3.0	15.0
7	60-64	3.7	18.5
8	65-69	4.3	21.5
9	70-74	5.0	25.0
10	75-79	5.7	28.5
11	80 or more	6.0	30.0

The hearing loss in decibels in Column 1 is the arithmetic average of thresholds of hearing measured in each ear in turn by pure-tone, air- or bone-conduction audiometry at frequencies of 1 000, 2 000, 3 000 and 4 000 Hertz.

XV. Ear, Nose and Throat Conditions

For hearing impairment, see Sections XIII, “Traumatic Hearing Loss” and XIV, “Non-Traumatic Hearing Loss”.

A. Vestibular Disorders

The following table is adapted from the AMA Guides, 5th Edition.

		Percentage
Grade 1	Symptoms or signs of vestibular disequilibrium present without supporting objective findings AND Activities of daily living can be performed without assistance	0
Grade 2	Symptoms or signs of vestibular disequilibrium present with supporting objective findings AND Activities of daily living can be performed without assistance except for complex activities such as bicycle riding or certain types of demanding activities related to individual work, such as walking on girders or scaffolds	0 – 10
Grade 3	Symptoms or signs of vestibular disequilibrium present with supporting objective findings AND Activities of daily living cannot be performed without assistance except for simple activities such as self care, some household duties, walking and riding in a motor vehicle operated by another person	11 – 30
Grade 4	Symptoms and signs of vestibular disequilibrium present with supporting objective findings AND Activities of daily living cannot be performed without assistance, except self care.	31 – 60
Grade 5	Symptoms and signs of vestibular disequilibrium present with supporting objective findings AND Activities of daily living cannot be performed without assistance except self care not requiring ambulation AND Home confinement is necessary	61 – 95

B. Temporomandibular Joint Dysfunction

The percentage of disability rated for temporomandibular joint dysfunction is the higher of the rating for loss of range of motion, structural change or malocclusion.

The rating should reflect loss of movement, structural change or malocclusion, whichever is the greatest.

Temporomandibular joint dysfunction is rarely so severe that it causes disability.

1. Loss of Range of Motion

	Percentage
Vertical movement loss	
40 mm (total loss)	10
30 mm	7
20 mm	5
10 mm	3
Lateral movement loss	
50% or more	5
Less than 50%	2.5
Protrusive movement loss	
Total loss	2

(Range of motion losses are added for total disability values)

2. Structural Change

Percentage

Recurrent subluxating or dislocating disc:

Unilateral 1
Bilateral 3

Recurrent subluxating or dislocating joint:

Unilateral 2
Bilateral 4

Meniscal repair or meniscectomy:

Unilateral 2
Bilateral 4

Meniscectomy and alloplastic implant or soft tissue:

Unilateral 5
Bilateral 10

Arthroplasty (total joint) reconstruction/resection:

Unilateral 5
Bilateral 10

Arthroscopic surgical debridement/synovectomy:

Unilateral 1.5
Bilateral 3

3. Malocclusion (Post-Traumatic)

That cannot be resolved by current orthodontic approaches 1.5

XVI. Cardiovascular System Conditions

AP Angina pectoris

CHF Congestive heart failure

EF Ejection fraction = the fraction of blood ejected by the heart in one beat

Normal = > 0.50

Mild systolic dysfunction = 0.40 - 0.50

Moderate systolic dysfunction = 0.30 - 0.40

Severe systolic dysfunction = < 0.30

HF Heart failure

HR Heart rate

MET A unit of measurement of heat production by the body; the metabolic heat produced by a resting/sitting subject, being 50 kgm calories per metre of body surface per hour; energy expended during a given activity is usually expressed in multiples of this resting metabolic energy or "METS".

MI Myocardial infarction

VT Ventricular tachycardia

XVI. Cardiovascular System Conditions

A. Coronary Artery Disease

		Percentage
Grade 1	Equivocal history of angina pectoris (AP) and angiography shows less than 50% reduction of cross-sectional area of coronary artery with normal EF	0 – 9
Grade 2	History of MI or AP documented by appropriate laboratory studies, with no symptoms with daily activity or moderately heavy exertion (functional class I) AND May require moderate dietary adjustment or medication to prevent AP or remain free of signs and symptoms of CHF AND Able to exercise on treadmill or cycle ergometer to obtain H.R. 90% of predicted max. without significant ST segment shift, VT, or hypertension; may be omitted if unable to perform METS >7 OR Recovered from coronary artery surgery or angioplasty, remains asymptomatic during daily activities and able to exercise as noted above. If taking beta-adrenergic blocking agent, should walk on treadmill to cause energy expenditure of at least 7 METS as substitute for target HR	10 – 29
Grade 3	History of MI documented by appropriate laboratory studies, or AP documented by changes on resting or exercise ECG, or radioisotope study suggestive of ischemia OR Either fixed or dynamic focal obstruction of at least 50% of coronary artery on angiography and function testing AND Requires moderate dietary adjustment or drugs to prevent frequent angina or to remain free of symptoms and signs of CHF but may develop AP after moderately heavy physical exertion (Functional Class II); METS > 5 but < 7. OR	30 – 49

	Has recovered from coronary artery surgery or angioplasty, continues to require treatment and has symptoms as described above.	
Grade 4	History of MI documented by appropriate laboratory studies or AP documented by changes on resting ECG or radioisotope study highly suggestive of myocardial ischemia OR Either fixed or dynamic focal obstruction of at least 50% of one or more coronary arteries demonstrated by angiography and function testing AND Requires moderate dietary adjustments or drugs to prevent AP or to remain free of symptoms and signs of CHF but continues to develop symptoms of AP or CHF during ordinary daily activities (Functional Class III or IV); ETS < 5 OR Has recovered from coronary artery bypass surgery or angioplasty and continues to require treatment and have symptoms as noted above.	50 – 100

Maximum and 90% Maximum Heart Rate									
Heart Rate by Age									
		30	**35**	**40**	**45**	**50**	**55**	**60**	**65**
	Max	193	191	189	187	184	182	180	178
Men	90% Max	173	172	170	168	166	164	162	160
	Max	190	185	181	177	172	168	163	159
Women	90% Max	171	167	163	159	155	151	147	143

New York Heart Association
Functional Classification of Cardiac Disease

CLASS	DESCRIPTION
I	Individual has cardiac disease but no resulting limitation of physical activity; ordinary physical activity does not cause undue fatigue, palpitation, dyspnea or anginal pain.
II	Individual has cardiac disease resulting in slight limitation of physical activity; is comfortable at rest and in the performance of ordinary light, daily activities; greater than ordinary physical activity, such as heavy physical exertion, results in fatigue, palpitation, dyspnea, or anginal pain.
III	Individual has cardiac disease resulting in marked limitation of physical activity; is comfortable at rest; ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.
IV	Individual has cardiac disease resulting in inability to carry on any physical activity without discomfort; symptoms of inadequate cardiac output, pulmonary congestion, systemic congestion, or anginal syndrome may be present, even at rest; if any physical activity is undertaken, discomfort is increased.

Relationship of METS and Functional Class According to Five Treadmill Protocols*

METS	1.6	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Treadmill tests																
Ellestad																
Miles per hour					1.7		3.0			4.0						5.0
% grade					10		10			10						10
Bruce																
Miles per hour					1.7		2.5			3.4			4.2			
% grade					10		12			14			16			
Balke																
Miles per hour				3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4
% grade				2	4	6	8	10	12	14	16	18	20	22	24	26
Balke																
Miles per hour			3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0				
% grade			0	2.5	5	7.5	10	12.5	15	17.5	20	22.5				
Naughton																
Miles per hour	1.0	2.0	2.0	2.0	2.0	2.0	2.0									
% grade	0	0	3.5	7	10.5	14	17.5									

METS	1.6	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Clinical status																
Symptomatic patients	←						→									
Diseased, recovered		←					→									
Sedentary healthy				←						→						
Physically active					←											→
Functional class	IV	←	III	→	←	II	→	←				I and Normal				→

*Adapted from: Fox SM III, Naughton JP, Haskell WL. Physical activity and the prevention of coronary heart disease. *Ann Clin Res.* 1971;3:404-432.[3]

Energy Expenditure in METS During Bicycle Ergometry*

Body Weight		Work Rate on Bicycle Ergometer, kg m^{-1} min^{-1} (Watts)												
kg	(lb)	75	150	300	450	600	750	900	1050	1200	1350	1500	1650	1800
(12)	(25)	(50)	(75)	(100)	(125)	(150)	(175)	(200)	(225)	(250)	(275)	(300)		
20	(44)	4.0	6.0	10.0	14.0	18.0	22.0							
30	(66)	3.4	4.7	7.3	10.0	12.7	15.3	17.9	20.7	23.3				
40	(88)	3.0	4.0	6.0	8.0	10.0	12.0	14.0	16.0	18.0	20.0	22.0		
50	(110)	2.8	3.6	5.2	6.8	8.4	10.0	11.5	13.2	14.8	16.3	18.0	19.6	21.1
60	(132)	2.7	3.3	4.7	6.0	7.3	8.7	10.0	11.3	12.7	14.0	15.3	16.7	18.0
70	(154)	2.6	3.1	4.3	5.4	6.6	7.7	8.8	10.0	11.1	12.2	13.4	14.0	15.7
80	(176)	2.5	3.0	4.0	5.0	6.0	7.0	8.0	9.0	10.0	11.0	12.0	13.0	14.0
90	(198)	2.4	2.9	3.8	4.7	5.6	6.4	7.3	8.2	9.1	10.0	10.9	11.8	12.6
100	(220)	2.4	2.8	3.6	4.4	5.2	6.0	6.8	7.6	8.4	9.2	10.0	10.8	11.6
110	(242)	2.4	2.7	3.4	4.2	4.9	5.6	6.3	7.1	7.8	8.5	9.3	10.0	10.7
120	(264)	2.3	2.7	3.3	4.0	4.7	5.3	6.0	6.7	7.3	8.0	8.7	9.3	10.0

*Source: American College of Sports Medicine. *Guidelines for Graded Exercise Testing and Exercise Prescription.* Philadelphia, Pa: Lea and Febiger; 1975:17.

B. Pericardial Disease

		Percentage
Grade 1	No symptoms with normal daily activities or moderately heavy physical exertion but evidence from either physical examination or laboratory studies of pericardial disease AND Continuous treatment not required, and no signs of cardiac enlargement or of congestion of lungs or other organs OR In an individual who has had surgical removal of the pericardium or a surgical window for drainage, no adverse consequences from treatment and meets above criteria	0 – 9
Grade 2	No symptoms in performance of ordinary daily activities, but evidence from either physical examination or laboratory studies of pericardial disease AND Dietary adjustment or drugs required to keep individual free of symptoms and signs of CHF OR Has recovered from pericardiectomy and meets above criteria	10 – 29
Grade 3	Slight to moderate discomfort in performance of ordinary daily activities (Functional Class II) despite dietary or drug therapy, and has evidence of pericardial disease on physical examination or laboratory studies AND Physical signs present of increased venous pressure or laboratory evidence of constrictive physiology on echocardio-graphic or hemodynamic evaluation OR Has recovered from surgery to remove pericardium but continues to have symptoms, signs, and laboratory evidence described above	30 – 49
Grade 4	Symptoms on performance of ordinary daily activities (Functional Class III or IV) despite appropriate dietary restrictions or drugs, and evidence from physical examination or laboratory studies of pericardial disease	50 – 100

AND

Has recovered from surgical pericardiectomy and continues to have symptoms, signs, and laboratory evidence described above.

C. Arrhythmias

		Percentage
Grade 1	Asymptomatic during ordinary activities and a cardiac arrhythmia is documented by ECG, or has had an isolated syncopal episode AND No documentation of three or more consecutive ectopic beats or periods of asystole > 1.5 seconds and both atrial and ventricular rates are maintained between 50 and 100 beats per minute AND No evidence of organic heart disease OR Has recovered from surgery or a catheter procedure to correct arrhythmia and above criteria are met	0 – 9
Grade 2	Asymptomatic during ordinary activities. A cardiac arrhythmia is documented by ECG, or has had an isolated syncopal episode AND Moderate dietary adjustment, use of drugs, or an artificial pacemaker required to prevent symptoms related to the arrhythmia OR Arrhythmia persists and there is organic heart disease OR Has recovered from surgery or a catheter procedure to correct arrhythmia or implantable cardioverter-defibrillator placement to treat arrhythmia and meets above criteria for impairment	10 – 29
Grade 3	Symptoms despite use of dietary or drug therapy or of an artificial pacemaker, and a cardiac arrhythmia is documented with ECG AND	30 – 49

	Is able to lead an active life and symptoms due to arrhythmia are limited to infrequent palpitations and/or episodes of light-headedness, presyncope, or temporary inadequate cardiac output OR Has recovered from surgery and catheter procedure, or implantable cardioverter-defibrillator placement to treat arrhythmia and meets above criteria for impairment	
Grade 4	Symptoms due to documented cardiac arrhythmia that are constant and interfere with ordinary daily activities (Functional Class III or IV) OR Frequent symptoms of inadequate cardiac output documented by ECG to be due to frequent episodes of cardiac arrhythmia OR Continues to have episodes of syncope that are either due to, or have a probability of being related to, arrhythmia; to fit into this category of impairment, symptoms must be present despite use of dietary therapy, drugs, or artificial pacemakers OR Has recovered from surgery, a catheter procedure or implantable cardioverter-defibrillator placement to treat arrhythmia and continues to have symptoms causing impairment outlined above	50 – 100

D. Hypertension

		Percentage
Grade 1	Asymptomatic; stage 1 or 2 hypertension without medications OR Normal blood pressure on antihypertensive medication AND No evidence of end organ damage	0 – 9
Grade 2	Asymptomatic; stage 1 or 2 hypertension despite multiple medications OR Antihypertensive medication with any of the following: (a) Proteinuria, urinary sediment abnormalities, no renal function impairment as measured by the blood urea nitrogen (BUN) and serum creatinine (b) Definite hypertensive = changes on fundoscopic examination in arterioles, e.g. "copper" or "silver wiring", or arteriovenous crossing changes with or without hemorrhages and exudates; either abnormality suggests end-organ damage	10 – 29
Grade 3	Asymptomatic; stage 3 hypertension despite multiple medications OR Antihypertensive medication with any of the following: (a) Proteinuria, urinary sediment abnormalities, renal function impairment as measured by BUN and serum creatinine, and a decreased creatinine clearance of 20% to 50% of normal (b) L.V. hypertrophy by ECG or echocardiography but no symptoms of HF; either abnormality suggests end-organ damage	30 – 49
Grade 4	Antihypertensive medication with Stages 1 - 3 and any of the following abnormalities: (a) Proteinuria, urinary sediment abnormalities, renal function impairment as measured by BUN and serum creatinine, and a creatinine clearance < 20% of normal (b) Hypertensive cerebrovascular damage or episodic hypertensive encephalopathy LV	50 – 100

hypertrophy systolic dysfunction, and/or signs and symptoms of HF due to hypertension

	Classification Adult Hypertension					
	Blood Pressure Categories			Hypertension Categories		
Blood Pressure	Optimal	Normal	High Normal	Stage 1	Stage 2	Stage 3
Systolic Diastolic	< 120 and < 80	< 130 and < 85	130 - 139 or 85 - 89	140 - 159 or 90 - 99	160 - 179 or 100 - 109	≥ 180 or ≥ 110

E. Pulmonary Hypertension

		Percentage
Grade 1	No symptoms or signs of right HF and mild pulmonary hypertension (PAP 40-50 mm Hg) or a Doppler echocardiography derived peak tricuspid velocity of 3.0-3.5 m/sec	0 – 9
Grade 2	No symptoms or signs of right HF and moderate P.A. hypertension (PAP 51-75 mm Hg)	10 – 29
Grade 3	Moderate pulmonary hypertension (PAP > 75 mm Hg) AND Signs and symptoms of right HF OR Symptoms of mild limitation (Class II) with any degree of pulmonary hypertension	30 – 49
Grade 4	Severe pulmonary hypertension (PAP > 75 mm Hg) OR Symptoms of severe limitation (Class III or IV) with any degree of pulmonary hypertension	50 – 100

F. Upper Extremity Peripheral Vascular Disease

		Percentage
Grade 1	Neither intermittent claudication nor pain at rest OR Only transient edema AND Physical examination not more than the following present: Loss of pulses; minimal loss of subcutaneous tissue of fingertips; calcification of arteries on x-ray; asymptomatic dilation of arteries or veins, not requiring surgery and not resulting in curtailment of activity OR Raynaud's symptoms with or without obstructive physiology (documented by finger/brachial indices of > 0.8 or low digital temperatures with decreased laser Doppler signals that do not normalize with warming of affected digits) that completely responds to lifestyle changes and/or medical therapy	0 – 4
Grade 2	Intermittent claudication on severe upper extremity usage OR Persistent edema of a moderate degree, controlled by elastic supports OR Vascular damage evidenced by a sign such as a healed, painless stump of an amputated digit showing evidence of persistent vascular disease, or a healed ulcer OR Raynaud's Phenomena with obstructive physiology (as documented by finger/brachial indices of < 0.8 or low digital temperatures with decreased laser Doppler signals that do not normalize with warming of affected digits) that incompletely responds to lifestyle changes and/or medical therapy	5 – 16
Grade 3	Intermittent claudication on mild upper extremity usage OR Marked edema that is controlled by elastic supports	17 – 27

	OR Vascular damage evidenced by healed amputation of two or more digits of one extremity with evidence of persistent vascular disease or superficial ulceration	
Grade 4	Intermittent claudication on mild upper extremity usage OR Marked edema that cannot be controlled by elastic support OR Vascular damage as evidenced by signs such as amputation at or above the wrist, or amputation of two or more digits of both extremities with evidence of persistent vascular disease; or persistent widespread or deep ulceration involving one extremity	28 – 35
Grade 5	Severe and constant pain at rest OR Vascular damage evidenced by signs such as amputation at or above the wrists of both extremities, or amputation of all digits of both extremities with evidence of persistent widespread or deep ulceration involving both extremities	36 – 40

G. Lower Extremity Peripheral Vascular Disease

		Percentage
Grade 1	Neither intermittent claudication nor pain at rest OR Only transient edema AND On physical examination, not more than the following findings: Loss of pulses; minimal loss of subcutaneous tissue; calcification of arteries detected by x-ray; asymptomatic dilation of arteries or veins, not requiring surgery and not resulting in curtailment of activity	0 – 4
Grade 2	Intermittent claudication on severe extremity usage OR Persistent edema of a moderate degree controlled by elastic supports	5 – 16

	OR Vascular damage evidenced by a sign such as a healed, painless stump of an amputated digit showing evidence of persistent vascular disease, or a healed ulcer	
Grade 3	Intermittent claudication on walking as few as 25 yards and no more than 100 yards at average pace OR Marked edema only partially controlled by elastic supports AND Vascular damage evidenced by a sign such as healed amputation of two or more digits of one extremity, with evidence of persistent vascular disease or superficial ulceration	17 – 27
Grade 4	Intermittent claudication on walking less than 25 yards, or intermittent pain at rest OR Marked edema that cannot be controlled by elastic support AND Vascular damage as evidenced by signs such as healed amputation at or above an ankle or amputation of two or more digits of two extremities, with evidence of persistent vascular disease; or persistent widespread, or deep ulceration involving one extremity	28 – 35
Grade 5	Severe and constant pain at rest OR Vascular damage evidenced by signs such as amputation at or above ankles of two extremities, or amputation of all digits of two or more extremities, with evidence of persistent, widespread, or deep ulceration involving two or more extremities	36 – 40

Desirable Weights for Men by Height and Body Build (indoor clothing weighing 2.3 kg [5 lb] and shoes with 2.5-cm [1-in] heels)*

Height, in (cm)	Weight, lb (kg)		
	Small Frame	Medium Frame	Large Frame
62(157)	128-134(58.0-60.7)	131-141(59.2-63.9)	138-150(62.5-67.8)
63(160)	130-136(59.0-61.7)	133-143(60.3-64.9)	140-153(63.5-69.4)
64(163)	132-138(60.0-62.7)	135-145(61.3-66.0)	142-156(64.5-71.1)
65(165)	134-140(60.8-63.5)	137-148(62.1-67.0)	144-160(65.3-72.5)
66(168)	136-142(61.8-64.6)	139-151(63.2-68.7)	146-164(66.4-74.7)
67(170)	138-145(62.5-65.7)	142-154(64.3-69.8)	149-168(67.5-76.1)
68(173)	140-148(63.6-67.3)	145-157(65.9-71.4)	152-172(69.1-78.2)
69(175)	142-151(64.3-68.3)	148-160(66.9-72.4)	155-176(70.1-79.6)
70(178)	144-154(65.4-70.0)	151-163(68.6-74.0)	158-180(71.8-81.8)
71(180)	146-157(66.1-71.0)	154-166(69.7-75.1)	161-184(72.8-83.3)
72(183)	149-160(67.7-72.7)	157-170(71.3-77.2)	164-188(74.5-85.4)
73(185)	152-164(68.7-74.1)	160-174(72.4-78.6)	168-192(75.9-86.8)
74(188)	155-168(70.3-76.2)	164-178(74.4-80.7)	172-197(78.0-89.4)
75(190)	158-172(71.4-77.6)	167-182(75.4-82.2)	176-202(79.4-91.2)
76(193)	162-176(73.5-79.8)	171-187(77.6-84.8)	181-207(82.1-93.9)

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Desirable Weights for Women by Height and Body Build (indoor clothing weighing 1.4 kg [3 lb] and shoes with 2.5-cm [1-in] heels)*

Height, in (cm)	Weight, lb (kg)		
	Small Frame	Medium Frame	Large Frame
58(147)	102-111(46.2-50.2)	109-121(49.3-54.7)	118-131(53.3-59.3)
59(150)	103-113(46.7-51.3)	111-123(50.3-55.9)	120-134(54.4-60.9)
60(152)	104-115(47.1-52.1)	113-126(51.1-57.0)	122-137(55.2-61.9)
61(155)	106-118(48.1-53.6)	115-129(52.2-58.6)	125-140(56.8-63.6)
62(157)	108-121(48.8-54.6)	118-132(53.2-59.6)	128-143(57.8-64.6)
63(160)	111-124(50.3-56.2)	121-135(54.9-61.2)	131-147(59.4-66.7)
64(163)	114-127(51.9-57.8)	124-138(56.4-62.8)	134-151(61.0-68.8)
65(165)	117-130(53.0-58.9)	127-141(57.5-63.9)	137-155(62.0-70.2)
66(168)	120-133(54.6-60.5)	130-144(59.2-65.5)	140-159(63.7-72.4)
67(170)	123-136(55.7-61.6)	133-147(60.2-66.6)	143-163(64.8-73.8)
68(173)	126-139(57.3-63.2)	136-150(61.8-68.2)	146-167(66.4-75.9)
69(175)	129-142(58.3-64.2)	139-153(62.8-69.2)	149-170(67.4-76.9)
70(178)	132-145(60.0-65.9)	142-156(64.5-70.9)	152-173(69.0-78.6)
71(180)	135-148(61.0-66.9)	145-159(65.6-71.9)	155-176(70.1-79.6)
72(183)	138-151(62.6-68.4)	148-162(67.0-73.4)	158-179(71.6-81.2)

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XVII. Digestive System Conditions

A. Upper Digestive Tract Disease

		Percentage
Grade 1	Symptoms or signs of upper digestive tract disease, or anatomic loss or alteration AND Continuous treatment not required AND Maintains weight at desirable level OR No sequelae after surgical procedures	0 – 9
Grade 2	Symptoms and signs of upper digestive tract disease, or anatomic loss or alteration AND Requires appropriate dietary restrictions and drugs for control of symptoms, signs, or nutritional deficiency AND Weight loss below desirable weight does not exceed 10%	10 – 24
Grade 3	Symptoms and signs of upper digestive tract disease, or anatomic loss or alteration AND Appropriate dietary restrictions and drugs do not completely control symptoms, signs, or nutritional state OR 10%-20% weight loss below desirable weight due to upper digestive tract disorder	25 – 49
Grade 4	Symptoms and signs of upper digestive tract disease, or anatomic loss or alteration AND Symptoms uncontrolled by treatment OR Greater than 20% weight loss below the desirable weight due to upper digestive tract disorder	50 – 75

Note: Upper digestive tract = esophagus + stomach + small intestine + pancreas + liver + gall bladder

B. Colonic and Rectal Disorders

		Percentage
Grade 1	Symptoms and signs of colonic or rectal disease infrequent and of brief duration AND Limitation of activities, special diet or medication not required AND No systemic manifestations present and weight and nutritional state can be maintained at desirable level OR No sequelae after surgical procedures	0 – 9
Grade 2	Objective signs of colonic or rectal disease or anatomic loss or alteration AND Mild gastrointestinal symptoms with occasional disturbances of bowel unction, accompanied by moderate pain AND Minimal restriction of diet or mild symptomatic therapy may be necessary AND No impairment of nutrition results	10 – 24
Grade 3	Objective evidence of colonic or rectal disease, or anatomic loss or alteration AND Moderate to severe exacerbations with disturbance of bowel habit accompanied by periodic or continual pain AND Restrictions of activity, special diet, and drugs required during attacks AND Constitutional manifestations (fever, anemia, or weight loss)	25 – 49
Grade 4	Objective evidence of colonic or rectal disease, or anatomic loss or alteration AND	50 – 75

Persistent disturbances of bowel function present at rest with severe persistent pain

AND

Complete limitation of activity, continued restriction of diet, and medication do not entirely control symptoms

AND

Constitutional manifestations (fever, weight loss, or anemia) present

OR

No prolonged remission

C. Anal Disease

		Percentage
Grade 1	Signs of organic anal disease or anatomic loss or alteration OR Mild incontinence involving gas or liquid stool OR Anal symptoms mild, intermittent, and controlled by treatment	0 – 9
Grade 2	Signs of organic anal disease or anatomic loss or alteration AND Moderate but partial fecal incontinence requiring continual treatment OR Continual anal symptoms incompletely controlled by treatment	10 – 19
Grade 3	Signs of organic anal disease or anatomic loss or alteration AND Complete fecal incontinence OR Signs of organic anal disease and severe anal symptoms unresponsive to therapy	20 – 35

D. Liver Disease

		Percentage
Grade 1	Objective evidence of persistent liver disease; no symptoms of liver disease and no history of ascites, jaundice, or bleeding esophageal varices within 3 years AND Good nutrition and strength AND Biochemical studies indicate minimal disturbance of function OR Primary disorders of bilirubin metabolism	0 – 14
Grade 2	Objective evidence of chronic liver disease, no liver disease symptoms and no history of ascites, jaundice or bleeding esophageal varices within 3 years AND Good nutrition and strength AND Biochemical studies indicate more severe liver damage than Grade 1	15 – 29
Grade 3	Objective evidence of progressive chronic liver disease or history of jaundice, ascites, or bleeding esophageal varices within past year AND Possibly affected nutrition and strength OR Intermittent hepatic encephalopathy	30 – 49
Grade 4	Objective evidence of progressive chronic liver disease or persistent jaundice or bleeding esophageal varices with central nervous system manifestations of hepatic insufficiency AND Poor nutritional state	50 – 95

E. Biliary Tree Disease

		Percentage
Grade 1	Occasional biliary tract dysfunction episode	0 – 14
Grade 2	Recurrent biliary tract impairment, irrespective of treatment	15 – 29
Grade 3	Irreparable biliary tract obstruction with recurrent cholangitis	30 – 49
Grade 4	Persistent jaundice, progressive liver disease due to common bile duct obstruction	50 – 95

XVIII. Urogenital Tract Conditions

A. Upper Urinary Tract Disease

		Percentage
Grade 1	Diminution of upper urinary tract function as evidenced by creatinine clearance of 70-90 L/24h (52-62.5 ml/min) OR Intermittent symptoms and signs of upper urinary tract dysfunction that do not require continuous treatment or surveillance	0 – 14
Grade 2	Diminution of upper urinary tract function as evidenced by creatinine clearance of 60-75 L/24h (42-52 ml/min) OR Symptoms and signs of upper urinary tract disease or dysfunction necessitate continuous surveillance and frequent treatment, although creatinine clearance is greater than 75 L/24h (52 ml/min) OR Successful renal transplantation results in marked renal function improvement OR Only one kidney is functioning (at least 15% of whole person)	15 – 34
Grade 3	Diminution of upper urinary tract function as evidenced by creatinine clearance of 40-60 L/24h (28-42 ml/min) OR Symptoms and signs of upper urinary tract disease or dysfunction are completely controlled by surgical or continuous medical treatment although creatinine clearance is 60-75 L/24h (42-52 ml/min)	35 – 59
Grade 4	Diminution of upper urinary tract function as evidenced by creatinine clearance below 40 L/24h (28 ml/min) OR Symptoms and signs of upper urinary tract disease or dysfunction persist despite surgical or continuous medical treatment although creatinine clearance is 40-60 L/24h (28-42 ml/min) OR Renal function deterioration requires either peritoneal dialysis or hemodialysis	60 – 95

Note: Normal creatinine clearance
- males 130-200 L/24h (90-139 ml/min)
- females 115-180 L/24h (80-125 ml/min)

Note: A worker with only one functioning kidney may have normal renal function due to the efficiency of the remaining kidney; however, the normal safety factor is lost. Value for a worker with one functioning kidney loss is 15%.

B. Bladder Disorders

		Percentage
Grade 1	Clinical signs or sequelae requiring occasional treatment	0 – 5
Grade 2	Clinical signs or sequelae requiring continuing medical supervision and medication (e.g. recurring cystitis, incontinence controlled by medication)	6 – 15
Grade 3	Clinical signs or sequelae incompletely controlled with medical and surgical treatment (e.g. retention or partial intermittent incontinence)	16 – 30
Grade 4	Clinical signs or sequelae not controlled with medical and surgical treatment (e.g. total incontinence or complete urinary retention)	31 – 60

C. Urethral Disorders

		Percentage
(a)	Stricture	
	Grade 1 Requiring occasional dilation	0 – 5
	Grade 2 Requiring dilation	6 – 10
(b)	Fistula(e)	15
(c)	Diverticula(e) with recurrent complications	5

D. Penile Disorders

		Percentage
Grade 1	Sexual function is possible but with varying degrees of difficulty with erection, ejaculation, or sensation	0 – 9
Grade 2	Sexual function possible with sufficient erection but with impaired ejaculation and sensation	10 – 19
Grade 3	No sexual function possible	20

Penile implant with good sensation lower range of Grade 2; with poor sensation upper range Grade 2.

E. Vulvar/Vaginal Disorders

		Percentage
Grade 1	Sexual relations possible, but with slight difficulty (delivery by birth canal possible)	0 – 5
Grade 2	Sexual relations possible, but difficult (limited potential for vaginal delivery)	6 – 15
Grade 3	Sexual relations impossible (vaginal delivery not possible) and symptoms not controlled by medical or surgical treatment	16 – 20

Percentage

Loss of kidney 15

Loss of spleen 10

Testicular loss

- Unilateral – without sterility 2
- Unilateral – with sterility 7
- Bilateral 10

Surgical diversion disorders

- Ureterointestinal 40
- Ureterostomy 40
- Nephrostomy 40
- Esophagostomy 40
- Gastrostomy 40
- Jejunostomy 40
- Ileostomy 40
- Ileal pouch-anal anastomosis 40
- Colostomy 40

Hernia – persisting, failed surgical repair or inoperable

	Unilateral	**Bilateral**
Mild – small size, reducible	2	6
Moderate – medium size, difficult to reduce	5	15
Severe – large size, irreducible	7	21

XX. Psychological Disability

Due to overlapping symptoms across diagnoses and their potential interactions, psychological disability ratings are not made per diagnosis. All accepted psychological diagnoses are combined and rated as a whole.

A. Aphasia and Communication Disturbances

	Percentage
Mild - minimal disturbance in comprehension and production of language symbols of daily living	0 – 25
Moderate - moderate disturbance in comprehension and production of language symbols of daily living	30 – 70
Marked - inability to comprehend language symbols. Production of unintelligible or inappropriate language for daily activities	75 – 95
Extreme - complete inability to communicate or comprehend language symbols	100

B. Disturbances of Mental Status and Integrative Functioning

	Percentage
Mild - some impairment but ability remains to satisfactorily perform most activities of daily living	0 – 25
Moderate - impairment necessitates direction and supervision of daily living activities	30 – 70
Marked - impairment necessitates directed care under continued supervision and confinement in home or other facility	75 – 95
Extreme - individual is unable without supervision to care for self and be safe in any situation	100

C. Emotional (Mental) and Behavioural Disturbances

The impairment levels below relate to activities of daily living, social functioning, concentration and adaptation.

XX. Psychological Disability

	Percentage
Mild - impairment levels are compatible with most useful functioning	0 – 25
Moderate - impairment levels are compatible with some but not all useful functioning	30 – 70
Marked - impairment levels significantly impede useful functioning	75 – 95
Extreme - impairment levels preclude most useful functioning	100

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

XXI. Respiratory System Conditions

A Introduction

For purposes of rating, the respiratory system includes the following:

- The upper respiratory system: the nose, throat, larynx and trachea.
- The lower respiratory system: all other respiratory structures within the chest cavity, including the chest wall cage.

Lower respiratory system ratings are based on a combination of diagnosis, symptoms and the results of laboratory tests, specifically pulmonary function tests (PFT's) and imaging studies.

B. Upper Respiratory System Conditions

Percentage

Rhinitis - recurrent and unresponsive to treatment or withdrawal from exposure

- minor 1
- significant +/- ulceration 5

Ulceration - recurrent and unresponsive to treatment or withdrawal from exposure 5

Perforation of nasal septum

- Asymptomatic..... 0
- Symptomatic 2

Nasal obstruction

• unilateral	minor	 0
	significant	 1
	complete	 2
• bilateral	minor	 0
	significant	..... 2.5
	complete	 5

Tracheal obstruction

- minor ..... 0 – 10
- significant ..... 11 – 25

Tracheostomy scar without obstruction..... 0

Permanent tracheostomy 25

C. Lower Respiratory System Conditions

1. **General Principles**

   (a) An anatomical change such as circumscribed pleural plaque represents an impairment based on anatomic structure; however, if there is no abnormality of lung function, and no decrease in the ability to perform activities of daily living, then the impairment rating assigned would be 0%.

   (b) A specific impairment is established by considering the severity and prognosis of the condition and how the impairment affects the individual's ability to perform activities of daily living.

   (c) Symptomatic assessment, though diagnostically useful, provides limited quantitative information, and should not be used as the sole criterion for assessing impairment.

   (d) Pulmonary function tests are the most useful clinical studies for assessing pulmonary functional changes.

2. **Symptoms**

   (a) Dyspnea
   - most common symptom in pulmonary impairment.
   - non-specific - cardiac, hematologic metabolic, neurologic, psychological or physical fitness causes

American Thoracic Society (ATS) Classification of Dyspnea

Severity	*Definition by Historical Question/Response*
Mild	Do you have to walk more slowly on the level than people of your age because of breathlessness?
Moderate	Do you have to stop for breath when walking at your own pace on the level?
Severe	Do you ever have to stop for breath after walking about 100 yards or for a few minutes on the level?
Very Severe	Are you too breathless to leave the house, or breathless on dressing or undressing?

(b) Cough

- Document
  - presence/absence
  - productive/non-productive
  - relationship to work
  - duration
  - hemoptysis

Chronic bronchitis = sputum-producing cough that occurs on most days for at least 3 consecutive months a year for at least 2 consecutive years (ATS criteria)

(c) Hemoptysis

- Conditions that are often associated with hemoptysis include bronchogenic carcinoma, pulmonary emboli, bronchiectasis, tuberculosis, aspegilloma, and arteriovenous malformations.

(d) Wheezing

- high pitched musical sounds
- inspiratory or stridor suggests laryngeal causes
- expiratory suggests bronchospasm

(e) Symptoms Due to Thoracic Cage Abnormalities

- Such as spinal abnormalities (e.g. Kyphoscoliosis).
- Respiratory compromise is produced by a combination of restricted lung volume, decreased cross-sectional area of the vascular bed, and decrease in chest wall compliance which occurs with age.
- Progressive stiffness of the chest wall with age increases the work of breathing and causes hyperventilation. Hypoxia is a powerful pulmonary vasoconstrictor and further decreases vascular cross-sectional area, leading to cor pulmonale.
- Judge severity of respiratory impairment on criteria listed in "Forced Expiratory Manoeuvres", "Diffusing Capacity for Carbon Monoxide" and other criteria for rating impairment due to respiratory disease provided.

3. Tobacco Use and Environmental Exposure

(a) Tobacco Use

- Standard measure of "pack years":

$$\text{number of years of smoking} \times \text{number of packs smoked per day}$$

- Most frequent cause of chronic bronchitis, emphysema, and lung cancer, and can exacerbate asthma.
- Risk of bronchogenic carcinoma decreases progressively in the first 10-15 years after quitting smoking, stabilizing at a point slightly higher than someone who has never smoked.

(b) Environmental Exposure

- Exposure to toxic materials, irritative gases, fumes, mists or vapours, organic materials, fibrogenic dust, bioaerosols, paints, glues, pesticides and allergens as well as pets, cool-mist vaporizers, humidifiers, indoor hot tubs and chlorinated and ozonated swimming pools all may cause, or exacerbate respiratory disease.

4. Evaluation of Respiratory Disease

(a) Physical Examination

- Noisy breath sounds may indicate airflow obstruction.
- Pursed lip breathing during expiration may suggest chronic obstructive pulmonary disease (COPD).
- Inspiratory crackles heard in two thirds of people with chronic interstitial lung disease may be associated with restrictive respiratory impairment.
- Wheezes or rhonchi indicate bronchial abnormalities and are often heard in obstructive airway disease.
- Cyanosis unreliable indicator of severe pulmonary impairment, and requires pulse oximetry or arterial blood gas analysis for confirmation.
- Digital clubbing associated with pulmonary fibrosis, bronchiectasis, bronchogenic carcinoma, pleural tumors, lung abscess, empyema and cyanotic congenital heart disease.

(b) Chest X-ray

- Initial posteroanterior and lateral views in full inspiration

(c) Computed Tomography (CT) - High-Resolution CT (HRCT)

- More sensitive in evaluating certain pulmonary diseases, such as asbestosis.
- Conventional CT - 10 mm thick slices. Good for high radiographic attenuation lesions.
- HRCT - 1-2 mm thick slices. Good for low radiographic attenuation lesions.
- HRCT delivers significantly less whole body effective dose radiation than standard CT.

(d) Forced Expiratory Manoeuvres (Simple Spirometry)

- Spirometric testing equipment, calibration, and administration techniques must conform to the guidelines of the 1994 ATS Statement on Standardization of Spirometry.

- If tolerated by the worker, remove pulmonary medications up to 24 hours before spirometry or methacholine challenge testing to assess pulmonary function without the effects of medication.

- Measurements are made from at least three acceptable spirometric tracings that demonstrate uniformity pertaining to both the expiratory flow pattern and concordance of at least two of the test results within 5% of each other; to include the following:

  i) Forced vital capacity (FVC)
  ii) Forced expiratory volume in the first second (FEV_1)
  iii) Ratio of these measurements (FEV_1/FVC)

- Tracings with the highest FVC and FEV_1 are used to occur on different expiratory efforts.

- Repeat spirometry after bronchodilator administration if FEV_1/FVC is below 0.70 or if there is wheezing on physical examination.

- Use the spirogram indicating best effort, before or after bronchodilator administration, to determine FVC and FEV_1 for impairment assessment.

- To use pulmonary function measures, obtain measurements of the FVC, FEV_1, and Dco (Diffusing Capacity for Carbon Monoxide) and compare these to the appropriate predicted normal value tables in Appendix B. (Pulmonary Function Tables I, III, V, VII, IX and XI) For the average or mean predicted normal value, find the individual's age in the left-hand column and height along the top row; the predicted value lies at the intersection of the appropriate row and column. In addition, identify the lower limit of normal for the measure in question by using the appropriate predicted lower limit value tables in Appendix B. (Pulmonary Function Tables II, IV, VI, VIII, X, and XII) The lower limit of normal has been calculated based upon the standard convention of the lower limit of normal lying at the fifth percentile, below the upper 95% of the reference population, according to ATS recommendations.

- The ATS task force for the interpretation of pulmonary function recommends an adjustment on a population basis for predicted lung function in blacks.

- Multiply values for predicted normal FVC (Pulmonary Function Tables I and III) by 0.88, for predicted normal FEV_1 (Pulmonary Function Tables V and VII), by 0.88 and for normal single breath Dco (Pulmonary Tables IX and XI) by 0.93 for blacks.

- North American whites have larger spirometric values for a given age, height and gender than North American blacks.

- Reliable population data are not yet available for other ethnic groups, such as Hispanics, Native North Americans and Asians, although similar in tendencies to North American blacks, have been noticed in these racial groups, it is still recommended that the values for North American whites be used in assessing their respiratory impairment.

(e) Diffusing Capacity for Carbon Monoxide (Dco)

- Use a single breath Dco to evaluate all levels of impairment.

- Physiological factors affecting the gas transfer process include:

  i) Alveolar-capillary membrane thickness
  ii) Available gas exchange surface area
  iii) Gas solubility
  iv) Pulmonary capillary blood volume
  v) Hematocrit
  vi) Test gas concentration gradient across the alveolar-capillary membrane
  vii) Hemoglobin binding site availability

- Mechanical factors affecting Dco results include:

  i) Test gas inhalation speed
  ii) Inspiration depth
  iii) Period of breath holding
  iv) Expiration speed

- Extrapulmonary factors

i) Cigarette smoking can elevate blood CO levels causing as much as 10-12% hemoglobin saturation and decreasing Dco.
ii) Have worker not smoke for at least 8 hours before the test

- Use tables in Appendix B (Pulmonary Function Tables IX and XI) for predicted normal diffusing capacity.

- Use table in Appendix C (Impairment Classification for Respiratory Disease, Using Pulmonary Function and Exercise Tests) to determine respiratory impairment.

(f) Cardiopulmonary Exercise Testing

- Used to determine whether worker's complaint of dyspnea is due to respiratory or cardiac conditions.

- Exercise capacity is measured by oxygen consumption per unit time in millilitres per kilogram multiplied by minutes, or in metabolic equivalents (METS).

- Generally, an individual can sustain a work level equal to 40% of the individual's measured maximum oxygen consumption (VO_2 max) for an eight hour period.

Prolonged Physical Work Intensity/Oxygen Consumption

Work Intensity For 70 kg Person	Oxygen Consumption	Excess Energy Expenditure
Light work	7 ml/kg; 0.5 L/min	< 2 METS
Moderate work	8-15 ml/kg; 0.6-1.0 L/min	2-4 METS
Heavy work	16-20 ml/kg; 1.1-1.5 L/min	5-6 METS
Very heavy work	21-30 ml/kg; 1.6-2.0 L/min	7-9 METS
Arduous work	> 30 ml/kg; > 2.0 L/min	> 8 METS

(g) Arterial Blood Gases

- In most workers with obstructive lung disease, exercise capacity correlates with FEV, better than arterial partial pressure of oxygen (PO_2).

- For impairment evaluation, hypoxia must be measured on two separate occasions at least 4 weeks apart.

- Pulse oximetry often provides an adequate estimate of hypoxia and is less invasive than arterial blood gases.

- Arterial PO_2 less than 55 mm Hg is evidence of severe impairment if worker is at rest, breathing room air at sea level.

- Arterial PO_2 less than 60 mm Hg may also indicate severe impairment if the worker also has one or more of the following:

  i) Pulmonary hypertension
  ii) Cor pulmonale
  iii) Increasingly severe hypoxia during exercise testing
  iv) Erythrocytosis

(h) Rating Impairment Due to Respiratory Disease

- All workers being assessed for respiratory impairment require spirometry.

- A worker must meet all of the listed criteria except for VO_2 max in order to be considered non-impaired (see table in Appendix C "Impairment Classification For Respiratory Disease, Using Pulmonary Function and Exercise Tests").

- At least one of the listed criteria must be fulfilled to place an individual in any category with an impairment rating.

XXII. Asthma

Either Tables A (1-3), Table B or Table C apply to assess asthma severity. The following considerations determine which tables or table to apply:

- Tables A1, A2 and A3 are used to make a clinical assessment based upon lung function tests and medication needs. The scores from Tables A1, A2 and A3 are added to obtain a total score for asthma severity.
- If the total score from Tables A1, A2 and A3 is "0", Table B is used to assess the severity of subjective symptoms.
- If the score from Table B is also "0", Table C is used to assess sensitization in an asymptomatic worker, resulting in the need to avoid work environments containing a sensitizing agent.
- Based on the asthma severity score from Tables A (1-3), Table B or Table C, Table D is then used to assign a percentage disability rating.

Table A1: Post-bronchodilator FEV_1*

Score	FEV_1 % predicted
0	≥ lower limit of normal
1	70% – 80% of predicted
2	60% – 69% of predicted
3	50% – 59% of predicted
4	<50% of predicted

Table A2: Reversibility of FEV_1 or Degree of Airway Hyperresponsiveness

Score	% FEV_1 Change OR	PC_{20}** mg/ml or Equivalent (Degree of Airway Hyperresponsiveness)
0	<10%	>8 mg/ml
1	10% – 19%	8 mg/ml to >0.6 mg/ml
2	20% – 29%	0.6 mg/ml to >0.125 mg/ml
3	≥ 30%	≤ 0.125 mg/ml
4	n/a	n/a

Table A3: Minimum Medication Need

Score	Medication
0	None
1	Occasional (but not daily) bronchodilator and/or occasional (but not daily) bronchodilator alternative
2	Daily bronchodilator and/or daily bronchodilator alternative and/or daily low dose inhaled steroid (< 800µg of beclomethasone or equivalent)
3	Bronchodilator on demand and daily high-dose inhaled steroid (>800µg of beclomethasone or equivalent) or occasional course (1-3 courses per year) of systemic steroid
4	Bronchodilator on demand and daily high-dose inhaled steroid (>800µg of beclomethasone or equivalent) and daily or every other day systemic steroid

*FEV_1 indicates the "forced expiratory volume" of air exhaled during the first second of a forced breath.
**PC_{20} is the "provocative concentration" of a stimulus that causes a 20% fall in FEV_1.

If FEV_1 is ≥ to the lower limit of normal, PC_{20} should be determined and used for rating asthma severity; if FEV_1 is 70% to 80%, either reversibility or PC_{20} can be used; if FEV_1 is < 70% of the predicted, reversibility only is used for rating asthma severity.

Table B: Symptom Severity as Reported by the Treating Physician or Board Medical Advisor

Score	Symptoms
0	None
0.3	Shortness of breath on exertion
0.6	Shortness of breath and wheezing on moderate exertion
0.9	Shortness of breath, wheezing, cough, and chest tightness on mild exertion

Table C: Sensitization

Score	Sensitization
0	The worker is able to return to the workplace without experiencing asthmatic symptoms.
0.1 – 0.2	The worker reacts with asthmatic symptoms upon exposure to a sensitizing agent in the workplace, indicated by increased bronchial reactivity and/or a significant change in peak flow when the worker returns to the workplace under conditions that do not expose the worker to irritant levels of the sensitizing agent or other known respiratory irritants. After considering medical advice, the Board determines that the worker must avoid workplaces containing the sensitizing agent. In assessing the disability rating, the Board considers the extent to which the sensitizing agent is commonly found in work environments. Generally, the more common the sensitizing agent, the higher the disability rating.

Table D: Asthma Disability Rating

Score (Table A(1-3), B or C whichever is higher)	Percentage
0	0
0.1 – 0.2	1 – 2
0.3	3
0.6	6
0.9	9
1	10
2	14
3	18
4	22
5	26
6	30
7	34
8	42
9	50
10 - 11	51 - 100

XXIII. Contact Dermatitis

Grade	Signs and Symptoms	Treatment (see below for details)	Percentage
Grade 1	Skin disorder signs and symptoms not present when the worker is removed from a workplace sensitizing agent, but the worker reacts with recurrent signs and symptoms of marked extent and severity when exposed to the sensitizing agent. The worker experiences these signs and symptoms when the worker returns to the workplace under conditions that do not expose the worker to irritant levels of the sensitizing agent or other known dermal irritants. After considering medical advice, the Board determines that the worker must avoid workplaces containing the sensitizing agent. In assessing the disability rating, the Board considers the extent to which the sensitizing agent is commonly found in work environments. Generally, the more common the sensitizing agent, the higher the disability rating.	Requires no treatment.	1 – 2
Grade 2	Skin disorder signs and symptoms present or intermittently present.	Requires no or intermittent treatment with agents listed in 1 below.	3 – 5
Grade 3	Skin disorder signs and symptoms intermittently or constantly present.	Requires intermittent treatment with agents listed in 1 and 2 below.	6 – 24
Grade 4	Skin disorder signs and symptoms constantly present.	Constant treatment with agents listed in 1 and 2 below. Cases such as these are rare and require tertiary level medical input.	25 – 50

In evaluating the severity of the worker's condition and its effect on earning capacity, the Board may consider the limitations experienced by the worker in the worker's activities of daily living.

XXIII. Contact Dermatitis

1. Treatments

Topical Treatment

Topical treatment may be indicated for mild cases of contact dermatitis with limited site of involvement, acute contact dermatitis when the offending agent has been removed, or chronic contact dermatitis with limited symptoms.

Topical therapy frequently includes:

- Emollients, lubricants, moisturizers
- Non-alkaline cleansers instead of soap
- Cool compresses
- Lotions, such as calamine
- Topical corticosteroid creams, ointments, lotions, gels or spray
- Antibiotics

Systemic Treatment

- Antihistamines
- Antibiotics

2. Systemic Treatment (Other)

Systemic treatment may be indicated for control of itching and/or edema even in cases of limited extent. Systemic treatment may also be indicated for moderate to severe acute and/or chronic contact dermatitis. Such treatments include:

- Antihistamines
- Corticosteroids (oral or parenteral)
- Antibiotics (oral or parenteral)
- Psoralen (topical or oral) and ultraviolet A radiation (PUVA)
- Azathioprine
- Cyclosporin

APPENDIX A

ADULT PINCH AND GRIP STRENGTH, Mathiowetz et al. [Arch. Phys. Med. Rehabil. Vol. 66, Feb 85]

Table 1: Average Performance of All Subjects on Grip Strength (pounds)

		Men					Women				
Age	Hand	Mean	SD	SE	Low	High	Mean	SD	SE	Low	High
20-24	R	121.0	20.6	3.8	91	167	70.4	14.5	2.8	46	95
	L	104.5	21.8	4.0	71	150	61.0	13.1	2.6	33	88
25-29	R	120.8	23.0	4.4	78	158	74.5	13.9	2.7	48	97
	L	110.5	16.2	3.1	77	139	63.5	12.2	2.4	48	97
30-34	R	121.8	22.4	4.3	70	170	78.7	19.2	3.8	46	137
	L	110.4	21.7	4.2	64	145	68.0	17.7	3.5	36	115
35-39	R	119.7	24.0	4.8	76	176	74.1	10.8	2.2	50	99
	L	112.9	21.7	4.4	73	157	66.3	11.7	2.3	49	91
40-44	R	116.8	20.7	4.1	84	165	70.4	13.5	2.4	38	103
	L	112.8	18.7	3.7	73	157	62.3	13.8	2.5	35	94
45-49	R	109.9	23.0	4.3	65	155	62.2	15.1	3.0	39	100
	L	100.8	22.8	4.3	58	160	56.0	12.7	2.5	37	83
50-54	R	113.6	18.1	3.6	79	151	65.8	11.6	2.3	38	87
	L	101.9	17.0	3.4	70	143	57.3	10.7	2.1	35	76
55-59	R	101.1	26.7	5.8	59	154	57.3	12.5	2.5	33	86
	L	83.2	23.4	5.1	43	128	47.3	11.9	2.4	31	76
60-64	R	89.7	20.4	4.2	51	137	55.1	10.1	2.0	37	77
	L	76.8	20.3	4.1	27	116	45.7	10.1	2.0	29	66
65-69	R	91.1	20.6	4.0	56	131	49.6	9.7	1.8	35	74
	L	76.8	19.8	3.8	43	117	41.0	8.2	1.5	29	63
70-74	R	75.3	21.5	4.2	32	108	49.6	11.7	2.2	33	78
	L	64.8	18.1	3.7	32	93	41.5	10.2	1.9	23	67
75+	R	65.7	21.0	4.2	40	135	42.6	11.0	2.2	25	65
	L	55.0	17.0	3.4	31	119	37.6	8.9	1.7	24	61
All subjects	R	104.3	28.3	1.6	32	176	62.8	17.0	0.96	25	137
	L	93.1	27.6	1.6	27	160	53.9	15.7	0.88	23	115

ADULT PINCH AND GRIP STRENGTH, Mathiowetz et al. [Arch. Phys. Med. Rehabil. Vol. 66, Feb 85]

Table 1: Average Performance of All Subjects on Grip Strength (kilograms)

		Men					Women				
Age	Hand	Mean	SD	SE	Low	High	Mean	SD	SE	Low	High
20-24	R	54.9	9.3	1.7	41.3	75.7	31.9	6.6	1.3	20.9	43.1
	L	47.4	9.9	1.8	32.2	68.0	27.7	5.9	1.2	15.0	39.9
25-29	R	54.8	10.4	2.0	35.4	71.7	33.8	6.3	1.2	21.8	44.0
	L	50.1	7.3	1.4	34.9	63.0	28.8	5.5	1.1	21.8	44.0
30-34	R	55.2	10.2	2.0	31.8	77.1	35.7	8.7	1.7	20.9	62.1
	L	50.1	9.8	1.9	29.0	65.8	30.8	8.0	1.6	16.3	52.2
35-39	R	54.3	10.9	2.2	34.5	79.8	33.6	4.9	1.0	22.7	44.9
	L	51.2	9.8	2.0	33.1	71.2	30.1	5.3	1.0	22.2	41.3
40-44	R	53.0	9.4	1.9	38.1	74.8	31.9	6.1	1.1	17.2	46.7
	L	51.2	8.5	1.7	33.1	71.2	28.3	6.3	1.1	15.9	42.6
45-49	R	49.8	10.4	2.0	29.5	70.3	28.2	6.8	1.4	17.7	45.4
	L	45.7	10.3	2.0	26.3	72.6	25.4	5.8	1.1	16.8	37.6
50-54	R	51.5	8.2	1.6	35.8	68.5	29.8	5.3	1.0	17.2	39.5
	L	46.2	7.7	1.5	31.8	64.9	26.0	4.9	0.95	15.9	34.5
55-59	R	45.9	12.1	2.6	26.8	69.9	26.0	5.7	1.1	15.0	39.0
	L	37.7	10.6	2.3	19.5	58.1	21.5	5.4	1.1	14.1	34.5
60-64	R	40.7	9.3	1.9	23.1	62.1	25.0	4.6	0.91	16.8	34.9
	L	34.8	9.2	1.9	12.2	52.6	20.7	4.6	0.91	13.2	29.9
65-69	R	41.3	9.3	1.8	25.4	59.4	22.5	4.4	0.82	15.9	33.6
	L	34.8	9.0	1.7	19.5	53.1	18.6	3.7	0.68	13.2	28.6
70-74	R	34.2	9.8	1.9	14.5	49.0	22.5	5.3	1.0	15.0	35.4
	L	29.4	8.2	1.7	14.5	42.2	18.8	4.6	0.86	10.4	30.4
75+	R	29.8	9.5	1.9	18.1	61.2	19.3	5.0	1.0	11.3	29.5
	L	24.9	7.7	1.5	14.1	54.0	17.1	4.0	0.77	10.9	27.7
All subjects	R	47.3	12.8	0.73	14.5	79.8	28.5	7.7	0.44	11.3	62.1
	L	42.2	12.5	0.73	12.2	72.6	24.4	7.1	0.40	10.4	52.2

APPENDIX A

ADULT PINCH AND GRIP STRENGTH, Mathiowetz et al. [Arch. Phys. Med. Rehabil. Vol. 66, Feb 85]

Table 2: Average Performance of All Subjects on Key Pinch (pounds)

		Men					Women				
Age	Hand	Mean	SD	SE	Low	High	Mean	SD	SE	Low	High
20-24	R	26.0	3.5	0.65	21	34	17.6	2.0	0.39	14	23
	L	24.8	3.4	0.64	19	31	16.2	2.1	0.41	13	23
25-29	R	26.7	4.9	0.94	19	41	17.7	2.1	0.41	14	22
	L	25.0	4.4	0.85	19	39	16.6	2.1	0.41	13	22
30-34	R	26.4	4.8	0.93	20	36	18.7	3.0	0.60	13	25
	L	26.2	5.1	0.98	17	36	17.8	3.6	0.70	12	26
35-39	R	26.1	3.2	0.65	21	32	16.6	2.0	0.40	12	21
	L	25.6	3.9	0.77	18	32	16.0	2.7	0.53	12	22
40-44	R	25.6	2.6	0.50	21	31	16.7	3.1	0.56	10	24
	L	25.1	4.0	0.79	19	31	15.8	3.1	0.55	8	22
45-49	R	25.8	3.9	0.73	19	35	17.6	3.2	0.65	13	24
	L	24.8	4.4	0.84	18	42	16.6	2.9	0.58	12	24
50-54	R	26.7	4.4	0.88	20	34	16.7	2.5	0.50	12	22
	L	26.1	4.2	0.84	20	37	16.1	2.7	0.53	12	22
55-59	R	24.2	4.2	0.92	18	34	15.7	2.5	0.50	11	21
	L	23.0	4.7	1.02	13	31	14.7	2.2	0.44	12	19
60-64	R	23.2	5.4	1.13	14	37	15.5	2.7	0.55	10	20
	L	22.2	4.1	0.84	16	33	14.1	2.5	0.50	10	19
65-69	R	23.4	3.9	0.75	17	32	15.0	2.6	0.49	10	21
	L	22.0	3.6	0.70	17	28	14.3	2.8	0.53	10	20
70-74	R	19.3	2.4	0.47	16	25	14.5	2.9	0.54	8	22
	L	19.2	3.0	0.59	13	28	13.8	3.0	0.56	9	22
75+	R	20.5	4.6	0.91	9	31	12.6	2.3	0.45	8	17
	L	19.1	3.0	0.59	13	24	11.4	2.6	0.50	7	16
All subjects	R	24.5	4.6	0.26	9	41	16.2	3.0	0.17	8	25
	L	23.6	4.6	0.26	11	42	15.3	3.1	0.18	7	26

ADULT PINCH AND GRIP STRENGTH, Mathiowetz et al. [Arch. Phys. Med. Rehabil. Vol. 66, Feb 85]

Table 2: Average Performance of All Subjects on Key Pinch (kilograms)

		Men					Women				
Age	Hand	Mean	SD	SE	Low	High	Mean	SD	SE	Low	High
20-24	R	11.8	1.6	0.29	9.5	15.4	8.0	0.91	0.18	6.4	10.4
	L	11.2	1.5	0.29	8.6	14.1	7.3	1.0	0.19	5.9	10.4
25-29	R	12.1	2.2	0.43	8.6	18.6	8.0	1.0	0.19	6.4	10.0
	L	11.3	2.0	0.39	8.6	17.7	7.5	1.0	0.19	5.9	10.0
30-34	R	12.0	2.2	0.42	9.1	16.3	8.5	1.4	0.27	5.9	11.3
	L	11.9	2.3	0.44	7.7	16.3	8.1	1.6	0.32	5.4	11.8
35-39	R	11.8	1.5	0.29	9.5	14.5	7.5	0.9	0.18	5.4	9.5
	L	11.6	1.8	0.35	8.2	14.5	7.3	1.2	0.24	5.4	10.0
40-44	R	11.6	1.2	0.23	9.5	14.1	7.6	1.4	0.25	4.5	10.9
	L	11.4	1.8	0.36	8.6	14.1	7.2	1.4	0.25	3.6	10.0
45-49	R	11.7	1.8	0.33	8.6	15.9	8.0	1.5	0.29	5.9	10.9
	L	11.2	2.0	0.38	8.2	19.1	7.5	1.3	0.26	5.4	10.9
50-54	R	12.1	2.0	0.40	9.1	15.4	7.6	1.1	0.23	5.4	10.0
	L	11.8	1.9	0.38	9.1	16.8	7.3	1.2	0.24	5.4	10.0
55-59	R	11.0	1.9	0.42	8.2	15.4	7.1	1.1	0.23	5.0	9.5
	L	10.4	2.1	0.46	5.9	14.1	6.7	1.0	0.20	5.4	8.6
60-64	R	10.5	2.4	0.51	6.4	16.8	7.0	1.2	0.25	4.5	9.1
	L	10.1	1.9	0.38	7.3	15.0	6.4	1.1	0.23	4.5	8.6
65-69	R	10.6	1.8	0.34	7.7	14.5	6.8	1.2	0.22	4.5	9.5
	L	10.0	1.6	0.32	7.7	12.7	6.5	1.3	0.24	4.5	9.1
70-74	R	8.8	1.1	0.21	7.3	11.3	6.6	1.3	0.24	3.6	10.0
	L	8.7	1.4	0.27	5.9	12.7	6.3	1.4	0.25	4.1	10.0
75+	R	9.3	2.1	0.41	4.1	14.1	5.7	1.0	0.20	3.6	7.7
	L	8.7	1.4	0.27	5.9	10.9	5.2	1.2	0.23	3.2	7.3
All subjects	R	11.1	2.1	0.12	4.1	18.6	7.3	1.4	0.08	3.6	11.3
	L	10.7	2.1	0.12	5.0	19.1	6.9	1.4	0.08	3.2	11.8

APPENDIX B

Pulmonary Function Table I

Predicted Normal Forced Vital Capacity (FVC) in Litres for Men (BTPS)*

Age	Height (cm)																								
	146	148	150	152	154	156	158	160	162	164	166	168	170	172	174	176	178	180	182	184	186	188	190	192	194
18	3.72	3.84	3.96	4.08	4.20	4.32	4.44	4.56	4.68	4.80	4.92	5.04	5.16	5.28	5.40	5.52	5.64	5.76	5.88	6.00	6.12	6.24	6.36	6.48	6.60
20	3.68	3.80	3.92	4.04	4.16	4.28	4.40	4.52	4.64	4.76	4.88	5.00	5.12	5.24	5.36	5.48	5.60	5.72	5.84	5.96	6.08	6.20	6.32	6.44	6.56
22	3.64	3.76	3.88	4.00	4.12	4.24	4.36	4.48	4.60	4.72	4.84	4.96	5.08	5.20	5.32	5.44	5.56	5.68	5.80	5.92	6.04	6.16	6.28	6.40	6.52
24	3.60	3.72	3.84	3.95	4.08	4.20	4.32	4.44	4.56	4.68	4.80	4.92	5.04	5.16	5.28	5.40	5.52	5.64	5.76	5.88	6.00	6.12	6.24	6.36	6.48
26	3.55	3.67	3.79	3.91	4.03	4.15	4.27	4.39	4.51	4.63	4.75	4.87	4.99	5.11	5.23	5.35	5.47	5.59	5.71	5.83	5.95	6.07	6.19	6.31	6.43
28	3.51	3.63	3.75	3.87	3.99	4.11	4.23	4.35	4.47	4.59	4.71	4.83	4.95	5.07	5.19	5.31	5.43	5.55	5.67	5.79	5.91	6.03	6.15	6.27	6.39
30	3.47	3.59	3.71	3.83	3.95	4.07	4.19	4.31	4.43	4.55	4.67	4.79	4.91	5.03	5.15	5.27	5.39	5.51	5.63	5.75	5.87	5.99	6.11	6.23	6.35
32	3.43	3.55	3.67	3.79	3.91	4.03	4.15	4.27	4.39	4.51	4.63	4.75	4.87	4.99	5.11	5.23	5.35	5.47	5.59	5.71	5.83	5.95	6.07	6.19	6.31
34	3.38	3.50	3.62	3.74	3.86	3.98	4.10	4.22	4.34	4.46	4.58	4.70	4.82	4.94	5.06	5.18	5.30	5.42	5.54	5.66	5.78	5.90	6.02	6.14	6.26
36	3.34	3.46	3.58	3.70	3.82	3.94	4.06	4.18	4.30	4.42	4.54	4.66	4.78	4.90	5.02	5.14	5.26	5.38	5.50	5.62	5.74	5.86	5.98	6.10	6.22
38	3.30	3.42	3.54	3.66	3.78	3.90	4.02	4.14	4.26	4.38	4.50	4.62	4.74	4.86	4.98	5.10	5.22	5.34	5.46	5.58	5.70	5.82	5.94	6.06	6.18
40	3.25	3.37	3.49	3.61	3.73	3.85	3.97	4.09	4.21	4.33	4.45	4.57	4.69	4.81	4.93	5.05	5.17	5.29	5.41	5.53	5.65	5.77	5.89	6.01	6.13
42	3.21	3.33	3.45	3.57	3.69	3.81	3.93	4.05	4.17	4.29	4.41	4.53	4.65	4.77	4.89	5.01	5.13	5.25	5.37	5.49	5.61	5.73	5.85	5.97	6.09
44	3.17	3.29	3.41	3.53	3.65	3.77	3.89	4.01	4.13	4.25	4.37	4.49	4.61	4.73	4.85	4.97	5.09	5.21	5.33	5.45	5.57	5.69	5.81	5.93	6.05
46	3.13	3.25	3.37	3.49	3.61	3.73	3.85	3.97	4.09	4.21	4.33	4.45	4.57	4.69	4.81	4.93	5.05	5.17	5.29	5.41	5.53	5.65	5.77	5.89	6.01
48	3.08	3.20	3.32	3.44	3.56	3.68	3.80	3.92	4.04	4.16	4.28	4.40	4.52	4.64	4.76	4.88	5.00	5.12	5.24	5.36	5.48	5.60	5.72	5.84	5.96
50	3.04	3.16	3.28	3.40	3.52	3.64	3.76	3.88	4.00	4.12	4.24	4.36	4.48	4.60	4.72	4.84	4.96	5.08	5.20	5.32	5.44	5.56	5.68	5.80	5.92
52	3.00	3.12	3.24	3.36	3.48	3.60	3.72	3.84	3.96	4.08	4.20	4.32	4.44	4.56	4.68	4.80	4.92	5.04	5.16	5.28	5.40	5.52	5.64	5.76	5.88
54	2.95	3.07	3.19	3.31	3.43	3.55	3.67	3.79	3.91	4.03	4.15	4.27	4.39	4.51	4.63	4.75	4.87	4.99	5.11	5.23	5.35	5.47	5.59	5.71	5.83
56	2.91	3.03	3.15	3.27	3.39	3.51	3.63	3.75	3.87	3.99	4.11	4.23	4.35	4.47	4.59	4.71	4.83	4.95	5.07	5.19	5.31	5.43	5.55	5.67	5.79
58	2.87	2.99	3.11	3.23	3.35	3.47	3.59	3.71	3.83	3.95	4.07	4.19	4.31	4.43	4.55	4.67	4.79	4.91	5.03	5.15	5.27	5.39	5.51	5.63	5.75
60	2.83	2.95	3.07	3.19	3.31	3.43	3.55	3.67	3.79	3.91	4.03	4.15	4.27	4.39	4.51	4.63	4.75	4.87	4.99	5.11	5.23	5.35	5.47	5.59	5.71
62	2.78	2.90	3.02	3.14	3.26	3.38	3.50	3.62	3.74	3.86	3.98	4.10	4.22	3.34	4.46	4.58	4.70	4.82	4.94	5.06	5.18	5.30	5.42	5.54	5.66
64	2.74	2.86	2.98	3.10	3.22	3.34	3.46	3.58	3.70	3.82	3.94	4.06	4.18	4.30	4.42	4.54	4.66	4.78	4.90	5.02	5.14	5.26	5.38	5.50	5.62
66	2.70	2.82	2.94	3.06	3.18	3.30	3.42	3.54	3.66	3.78	3.90	4.02	4.14	4.26	4.38	4.50	4.62	4.74	4.86	4.98	5.10	5.22	5.34	5.46	5.58
68	2.65	2.77	2.89	3.01	3.13	3.25	3.37	3.49	3.61	3.73	3.85	3.97	4.09	4.21	4.33	4.45	4.57	4.69	4.81	4.93	5.05	5.17	5.29	5.41	5.53
70	2.61	2.73	2.85	2.97	3.09	3.21	3.33	3.45	3.57	3.69	3.81	3.93	4.05	4.17	4.29	4.41	4.53	4.65	4.77	4.89	5.01	5.13	5.25	5.37	5.49
72	2.57	2.69	2.81	2.93	3.05	3.17	3.29	3.41	3.53	3.65	3.77	3.89	4.01	4.13	4.25	4.37	4.49	4.61	4.73	4.85	4.97	5.09	5.21	5.33	5.45
74	2.53	2.65	2.77	2.89	3.01	3.13	3.25	3.37	3.49	3.61	3.73	3.85	3.97	4.09	4.21	4.33	4.45	4.57	4.69	4.81	4.93	5.05	5.17	5.29	5.41

*FVC in litres = 0.0600 H – 0.0214 A – 4.650. R^2 = 0.54; SEE = 0.644; 95% confidence level = 1.115. Definitions of abbreviations: R^2 = coefficient of determination; SEE = standard error of estimate; H = height in cm; A = age in years. BTPS = body temperature, ambient pressure, and saturated with water vapour at these conditions. Adapted from Crapo et al.[2]

APPENDIX B

Pulmonary Function Table II

Predicted Lower Limit of Normal Forced Vital Capacity (FVC) for Men*

Age	Height (cm)																								
	146	148	150	152	154	156	158	160	162	164	166	168	170	172	174	176	178	180	182	184	186	188	190	192	194
18	2.605	2.725	2.845	2.965	3.085	3.205	3.325	3.445	3.565	3.685	3.805	3.925	4.045	4.165	4.285	4.405	4.525	4.645	4.765	4.885	5.005	5.125	5.245	5.365	5.485
20	2.565	2.685	2.805	2.925	3.045	3.165	3.285	3.405	3.525	3.645	3.765	3.885	4.005	4.125	4.245	4.365	4.485	4.605	4.725	4.845	4.965	5.085	5.205	5.325	5.445
22	2.525	2.645	2.765	2.885	3.005	3.125	3.245	3.365	3.485	3.605	3.725	3.845	3.965	4.085	4.205	4.325	4.445	4.565	4.685	4.805	4.925	5.045	5.165	5.285	5.405
24	2.485	2.605	2.725	2.835	2.965	3.085	3.205	3.325	3.445	3.565	3.685	3.805	3.925	4.045	4.165	4.285	4.405	4.525	4.645	4.765	4.885	5.005	5.125	5.245	5.365
26	2.435	2.555	2.675	2.795	2.915	3.035	3.155	3.275	3.395	3.515	3.635	3.755	3.875	3.995	4.115	4.235	4.355	4.475	4.595	4.715	4.835	4.955	5.075	5.195	5.315
28	2.395	2.515	2.635	2.755	2.875	2.995	3.115	3.235	3.355	3.475	3.595	3.715	3.835	3.955	4.075	4.195	4.315	4.435	4.555	4.675	4.795	4.915	5.035	5.155	5.275
30	2.355	2.475	2.595	2.715	2.835	2.955	3.075	3.195	3.315	3.435	3.555	3.675	3.795	3.915	4.035	4.155	4.275	4.395	4.515	4.635	4.755	4.875	4.995	5.115	5.235
32	2.315	2.435	2.555	2.675	2.795	2.915	3.035	3.155	3.275	3.395	3.515	3.635	3.755	3.875	3.995	4.115	4.235	4.355	4.475	4.595	4.715	4.835	4.955	5.075	5.195
34	2.265	2.385	2.505	2.625	2.745	2.865	2.985	3.105	3.225	3.345	3.465	3.585	3.705	3.825	3.945	4.065	4.185	4.305	4.425	4.545	4.665	4.785	4.905	5.025	5.145
36	2.225	2.345	2.465	2.585	2.705	2.825	2.945	3.065	3.185	3.305	3.425	3.545	3.665	3.785	3.905	4.025	4.145	4.265	4.385	4.505	4.625	4.745	4.865	4.985	5.105
38	2.185	2.305	2.425	2.545	2.665	2.785	2.905	3.025	3.145	3.265	3.385	3.505	3.625	3.745	3.865	3.985	4.105	4.225	4.345	4.465	4.585	4.705	4.825	4.945	5.065
40	2.135	2.255	2.375	2.495	2.615	2.735	2.855	2.975	3.095	3.215	3.335	3.455	3.575	3.695	3.815	3.935	4.055	4.175	4.295	4.415	4.535	4.655	4.775	4.895	5.015
42	2.095	2.215	2.335	2.455	2.575	2.695	2.815	2.935	3.055	3.175	3.295	3.415	3.535	3.655	3.775	3.895	4.015	4.135	4.255	4.375	4.495	4.615	4.735	4.855	4.975
44	2.055	2.175	2.295	2.415	2.535	2.655	2.775	2.895	3.015	3.135	3.255	3.375	3.495	3.615	3.735	3.855	3.975	4.095	4.215	4.335	4.455	4.575	4.695	4.815	4.935
46	2.015	2.135	2.255	2.375	2.495	2.615	2.735	2.855	2.975	3.095	3.215	3.335	3.455	3.575	3.695	3.815	3.935	4.055	4.175	4.295	4.415	4.535	4.655	4.775	4.895
48	1.965	2.085	2.205	2.325	2.445	2.565	2.685	2.805	2.925	3.045	3.165	3.285	3.405	3.525	3.645	3.765	3.885	4.005	4.125	4.245	4.365	4.485	4.605	4.725	4.845
50	1.925	2.045	2.165	2.285	2.405	2.525	2.645	2.765	2.885	3.005	3.125	3.245	3.365	3.485	3.605	3.725	3.845	3.965	4.085	4.205	4.325	4.445	4.565	4.685	4.805
52	1.885	2.005	2.125	2.245	2.365	2.485	2.605	2.725	2.845	2.965	3.085	3.205	3.325	3.445	3.565	3.685	3.805	3.925	4.045	4.165	4.285	4.405	4.525	4.645	4.765
54	1.835	1.955	2.075	2.195	2.315	2.435	2.555	2.675	2.795	2.915	3.035	3.155	3.275	3.395	3.515	3.635	3.755	3.875	3.995	4.115	4.235	4.355	4.475	4.595	4.715
56	1.795	1.915	2.035	2.155	2.275	2.395	2.515	2.635	2.755	2.875	2.995	3.115	3.235	3.355	3.475	3.595	3.715	3.835	3.955	4.075	4.195	4.315	4.435	4.555	4.675
58	1.755	1.875	1.995	2.115	2.235	2.355	2.475	2.595	2.715	2.835	2.955	3.075	3.195	3.315	3.435	3.555	3.675	3.795	3.915	4.035	4.155	4.275	4.395	4.515	4.635
60	1.715	1.835	1.955	2.075	2.195	2.315	2.435	2.555	2.675	2.795	2.915	3.035	3.155	3.275	3.395	3.515	3.635	3.755	3.875	3.995	4.115	4.235	4.355	4.475	4.595
62	1.665	1.785	1.905	2.025	2.145	2.265	2.385	2.505	2.625	2.745	2.865	2.985	3.105	3.225	3.345	3.465	3.585	3.705	3.825	3.945	4.065	4.185	4.305	4.425	4.545
64	1.625	1.745	1.865	1.985	2.105	2.225	2.345	2.465	2.585	2.705	2.825	2.945	3.065	3.185	3.305	3.425	3.545	3.665	3.785	3.905	4.025	4.145	4.265	4.385	4.505
66	1.585	1.705	1.825	1.945	2.065	2.185	2.305	2.425	2.545	2.665	2.785	2.905	3.025	3.145	3.265	3.385	3.505	3.625	3.745	3.865	3.985	4.105	4.225	4.345	4.465
68	1.535	1.655	1.775	1.895	2.015	2.135	2.255	2.375	2.495	2.615	2.735	2.855	2.975	3.095	3.215	3.335	3.455	3.575	3.695	3.815	3.935	4.055	4.175	4.295	4.415
70	1.495	1.615	1.735	1.855	1.975	2.095	2.215	2.335	2.455	2.575	2.695	2.815	2.935	3.055	3.175	3.295	3.415	3.535	3.655	3.775	3.895	4.015	4.135	4.255	4.375
72	1.455	1.575	1.695	1.815	1.935	2.055	2.175	2.295	2.415	2.535	2.655	2.775	2.895	3.015	3.135	3.255	3.375	3.495	3.615	3.735	3.855	3.975	4.095	4.215	4.335
74	1.415	1.535	1.655	1.775	1.895	2.015	2.135	2.255	2.375	2.495	2.615	2.735	2.855	2.975	3.095	3.215	3.335	3.455	3.575	3.695	3.815	3.935	4.055	4.175	3.180

*FVC values are given in litres. The values listed here reflect the FVC as listed in Table 5-2a minus 1.115 L (95% confidence interval). Adapted from Crapo et al.[2]

APPENDIX B

Pulmonary Function Table III

Predicted Normal Forced Vital Capacity (FVC) in Litres for Women (BTPS)*

Age	Height (cm)																								
	146	148	150	152	154	156	158	160	162	164	166	168	170	172	174	176	178	180	182	184	186	188	190	192	194
18	3.19	3.29	3.39	3.48	3.58	3.68	3.78	3.88	3.98	4.07	4.17	4.27	4.37	4.47	4.56	4.66	4.76	4.86	4.96	5.06	5.15	5.25	5.35	5.45	5.55
20	3.15	3.24	3.34	3.44	3.54	3.64	3.74	3.83	3.93	4.03	4.13	4.23	4.32	4.42	4.52	4.62	4.72	4.82	4.91	5.01	5.11	5.21	5.31	5.41	5.50
22	3.10	3.20	3.30	3.40	3.50	3.59	3.69	3.79	3.89	3.99	4.09	4.18	4.28	4.38	4.48	4.58	4.67	4.77	4.87	4.97	5.07	5.17	5.26	5.36	5.46
24	3.06	3.16	3.26	3.35	3.45	3.55	3.65	3.75	3.85	3.94	4.04	4.14	4.24	4.34	4.43	4.53	4.63	4.73	4.83	4.93	5.02	5.12	5.22	5.32	5.42
26	3.02	3.12	3.21	3.31	3.41	3.51	3.61	3.70	3.80	3.90	4.00	4.10	4.20	4.29	4.39	4.49	4.59	4.69	4.78	4.88	4.98	5.08	5.18	5.28	5.37
28	2.97	3.07	3.17	3.27	3.37	3.46	3.56	3.66	3.76	3.86	3.96	4.05	4.15	4.25	4.35	4.45	4.54	4.64	4.74	4.84	4.94	5.04	5.13	5.23	5.33
30	2.93	3.03	3.13	3.23	3.32	3.42	3.52	3.62	3.72	3.81	3.91	4.01	4.11	4.21	4.31	4.40	4.50	4.60	4.70	4.80	4.89	4.99	5.09	5.19	5.29
32	2.89	2.99	3.08	3.18	3.28	3.38	3.48	3.57	3.67	3.77	3.87	3.97	4.07	4.16	4.26	4.36	4.46	4.56	4.65	4.75	4.85	4.95	5.05	5.15	5.24
34	2.84	2.94	3.04	3.14	3.24	3.34	3.43	3.53	3.63	3.73	3.83	3.92	4.02	4.12	4.22	4.32	4.42	4.51	4.61	4.71	4.81	4.91	5.00	5.10	5.20
36	2.80	2.90	3.00	3.10	3.19	3.29	3.39	3.49	3.59	3.68	3.78	3.88	3.98	4.08	4.18	4.27	4.37	4.47	4.57	4.67	4.76	4.86	4.96	5.06	5.16
38	2.76	2.86	2.95	3.05	3.15	3.25	3.35	3.45	3.54	3.64	3.74	3.84	3.94	4.03	4.13	4.23	4.33	4.43	4.53	4.62	4.72	4.82	4.92	5.02	5.11
40	2.71	2.81	2.91	3.01	3.11	3.21	3.30	3.40	3.50	3.60	3.70	3.79	3.89	3.99	4.09	4.19	4.29	4.38	4.48	4.58	4.68	4.78	4.87	4.97	5.07
42	2.67	2.77	2.87	2.97	3.06	3.16	3.26	3.36	3.46	3.56	3.65	3.75	3.85	3.95	4.05	4.14	4.24	4.34	4.44	4.54	4.64	4.73	4.83	4.93	5.03
44	2.63	2.73	2.82	2.92	3.02	3.12	3.22	3.32	3.41	3.51	3.61	3.71	3.81	3.90	4.00	4.10	4.20	4.30	4.40	4.49	4.59	4.69	4.79	4.89	4.98
46	2.58	2.68	2.78	2.88	2.98	3.08	3.17	3.27	3.37	3.47	3.57	3.67	3.76	3.86	3.96	4.06	4.16	4.25	4.35	4.45	4.55	4.65	4.75	4.84	4.94
48	2.54	2.64	2.74	2.84	2.93	3.03	3.13	3.23	3.33	3.43	3.52	3.62	3.72	3.82	3.92	4.01	4.11	4.21	4.31	4.41	4.51	4.60	4.70	4.80	4.90
50	2.50	2.60	2.69	2.79	2.89	2.99	3.09	3.19	3.28	3.38	3.48	3.58	3.68	3.78	3.87	3.97	4.07	4.17	4.27	4.36	4.46	4.56	4.66	4.76	4.86
52	2.46	2.55	2.65	2.75	2.85	2.95	3.04	3.14	3.24	3.34	3.44	3.54	3.63	3.73	3.83	3.93	4.03	4.12	4.22	4.32	4.42	4.52	4.62	4.71	4.81
54	2.41	2.51	2.61	2.71	2.80	2.90	3.00	3.10	3.20	3.30	3.39	3.49	3.59	3.69	3.79	3.89	3.98	4.08	4.18	4.28	4.38	4.47	4.57	4.67	4.77
56	2.37	2.47	2.57	2.66	2.76	2.86	2.96	3.06	3.15	3.25	3.35	3.45	3.55	3.65	3.74	3.84	3.94	4.04	4.14	4.23	4.33	4.43	4.53	4.63	4.73
58	2.33	2.42	2.52	2.62	2.72	2.82	2.91	3.01	3.11	3.21	3.31	3.41	3.50	3.60	3.70	3.80	3.90	4.00	4.09	4.19	4.29	4.39	4.49	4.58	4.68
60	2.28	2.38	2.48	2.58	2.68	2.77	2.87	2.97	3.07	3.17	3.26	3.36	3.46	3.56	3.66	2.76	3.85	3.95	4.05	4.15	4.25	4.34	4.44	4.54	4.64
62	2.24	2.34	2.44	2.53	2.63	2.73	2.83	2.93	3.02	3.12	3.22	3.32	3.42	3.52	3.61	3.71	3.81	3.91	4.01	4.11	4.20	4.30	4.40	4.50	4.60
64	2.20	2.29	2.39	2.49	2.59	2.69	2.79	2.88	2.98	3.08	3.18	3.28	3.37	3.47	3.57	3.67	3.77	3.87	3.96	4.06	4.16	4.26	4.36	4.45	4.55
66	2.15	2.25	2.35	2.45	2.55	2.64	2.74	2.84	2.94	3.04	3.14	3.23	3.33	3.43	3.53	3.63	3.72	3.82	3.92	4.02	4.12	4.22	4.31	4.41	4.51
68	2.11	2.21	2.31	2.40	2.50	2.60	2.70	2.80	2.90	2.99	3.09	3.19	3.29	3.39	3.48	3.58	3.68	3.78	3.88	3.98	4.07	4.17	4.27	4.37	4.47
70	2.07	2.16	2.26	2.36	2.46	2.56	2.66	2.75	2.85	2.95	3.05	3.15	3.24	3.34	3.44	3.54	3.64	3.74	3.83	3.93	4.03	4.13	4.23	4.33	4.42
72	2.02	2.12	2.22	2.32	2.42	2.51	2.61	2.71	2.81	2.91	3.01	3.10	3.20	3.30	3.40	3.50	3.59	3.69	3.79	3.89	3.99	4.09	4.18	4.28	4.38
74	1.98	2.08	2.18	2.27	2.37	2.47	2.57	2.67	2.77	2.86	2.96	3.06	3.16	3.26	3.36	3.45	3.55	3.65	3.75	3.85	3.94	4.04	4.14	4.24	4.34

*FVC in litres = 0.0491 H – 0.0216 A – 3.590. R^2 = 0.74; SEE = 0.393; 95% confidence interval = 0.676. Definitions of abbreviations: R^2 = coefficient of determination; SEE = standard error of estimate; H = height in cm; A = age in years. BTPS = body temperature, ambient pressure, and saturated with water vapour at these conditions. Adapted from Crapo et al.[2]

APPENDIX B

Pulmonary Function Table IV

Predicted Lower Limit of Normal Forced Vital Capacity (FVC) for Women*

Age	Height (cm)																								
	146	148	150	152	154	156	158	160	162	164	166	168	170	172	174	176	178	180	182	184	186	188	190	192	194
18	2.514	2.614	2.714	2.804	2.904	3.004	3.104	3.204	3.304	3.394	3.494	3.594	3.694	3.794	3.884	3.984	4.084	4.184	4.284	4.384	4.474	4.574	4.674	4.774	4.874
20	2.474	2.564	2.664	2.764	2.864	2.964	3.064	3.154	3.254	3.354	3.454	3.554	3.644	3.744	3.844	3.944	4.044	4.144	4.234	4.334	4.434	4.534	4.634	4.734	4.824
22	2.424	2.524	2.624	2.724	2.824	2.914	3.014	3.114	3.214	3.314	3.414	3.504	3.604	3.704	3.804	3.904	3.994	4.094	4.194	4.294	4.394	4.494	4.584	4.684	4.784
24	2.384	2.484	2.584	2.674	2.774	2.874	2.974	3.074	3.174	3.264	3.364	3.464	3.564	3.664	3.754	3.854	3.954	4.054	4.154	4.254	4.344	4.444	4.544	4.644	4.744
26	2.344	2.444	2.534	2.634	2.734	2.834	2.934	3.024	3.124	3.224	3.324	3.424	3.524	3.614	3.714	3.814	3.914	4.014	4.104	4.204	4.304	4.404	4.504	4.604	4.694
28	2.294	2.394	2.494	2.594	2.694	2.784	2.884	2.984	3.084	3.184	3.284	3.374	3.474	3.574	3.674	3.774	3.864	3.964	4.064	4.164	4.264	4.364	4.454	4.554	4.654
30	2.254	2.354	2.454	2.554	2.644	2.744	2.844	2.944	3.044	3.134	3.234	3.334	3.434	3.534	3.634	3.724	3.824	3.924	4.024	4.124	4.214	4.314	4.414	4.514	4.614
32	2.214	2.314	2.404	2.504	2.604	2.704	2.804	2.894	2.994	3.094	3.194	3.294	3.394	3.484	3.584	3.684	3.784	3.884	3.974	4.074	4.174	4.274	4.374	4.474	4.564
34	2.164	2.264	2.364	2.464	2.564	2.664	2.754	2.854	2.954	3.054	3.154	3.244	3.344	3.444	3.544	3.644	3.744	3.834	3.934	4.034	4.134	4.234	4.324	4.424	4.524
36	2.124	2.224	2.324	2.424	2.514	2.614	2.714	2.814	2.914	3.004	3.104	3.204	3.304	3.404	3.504	3.594	3.694	3.794	3.894	3.994	4.084	4.184	4.284	4.384	4.484
38	2.084	2.184	2.274	2.374	2.474	2.574	2.674	2.774	2.864	2.964	3.064	3.164	3.264	3.354	3.454	3.554	3.654	3.754	3.854	3.944	4.044	4.144	4.244	4.344	4.434
40	2.034	2.134	2.234	2.334	2.434	2.534	2.624	2.724	2.824	2.924	3.024	3.114	3.214	3.314	3.414	3.514	3.614	3.704	3.804	3.904	4.004	4.104	4.194	4.294	4.394
42	1.994	2.094	2.194	2.294	2.384	2.484	2.584	2.684	2.784	2.884	2.974	3.074	3.174	3.274	3.374	3.464	3.564	3.664	3.764	3.864	3.964	4.054	4.154	4.254	4.354
44	1.954	2.054	2.144	2.244	2.344	2.444	2.544	2.644	2.734	2.834	2.934	3.034	3.134	3.224	3.324	3.424	3.524	3.624	3.724	3.814	3.914	4.014	4.114	4.214	4.304
46	1.904	2.004	2.104	2.204	2.304	2.404	2.494	2.594	2.694	2.794	2.894	2.994	3.084	3.184	3.284	3.384	3.484	3.574	3.674	3.774	3.874	3.974	4.074	4.164	4.264
48	1.864	1.964	2.064	2.164	2.254	2.354	2.454	2.554	2.654	2.754	2.844	2.944	3.044	3.144	3.244	3.334	3.434	3.534	3.634	3.734	3.834	3.924	4.024	4.124	4.224
50	1.824	1.924	2.014	2.114	2.214	2.314	2.414	2.514	2.604	2.704	2.804	2.904	3.004	3.104	3.194	3.294	3.394	3.494	3.594	3.684	3.784	3.884	3.984	4.084	4.184
52	1.784	1.874	1.974	2.074	2.174	2.274	2.364	2.464	2.564	2.664	2.764	2.864	2.954	3.054	3.154	3.254	3.354	3.444	3.544	3.644	3.744	3.844	3.944	4.034	4.134
54	1.734	1.834	1.934	2.034	2.124	2.224	2.324	2.424	2.524	2.624	2.714	2.814	2.914	3.014	3.114	3.214	3.304	3.404	3.504	3.604	3.704	3.794	3.894	3.994	4.094
56	1.694	1.794	1.894	1.984	2.084	2.184	2.284	2.384	2.474	2.574	2.674	2.774	2.874	2.974	3.064	3.164	3.264	3.364	3.464	3.554	3.654	3.754	3.854	3.954	4.054
58	1.654	1.744	1.844	1.944	2.044	2.144	2.234	2.334	2.434	2.534	2.634	2.734	2.824	2.924	3.024	3.124	3.224	3.324	3.414	3.514	3.614	3.714	3.814	3.904	4.004
60	1.604	1.704	1.804	1.904	2.004	2.094	2.194	2.294	2.394	2.494	2.584	2.684	2.784	2.884	2.984	2.084	3.174	3.274	3.374	3.474	3.574	3.664	3.764	3.864	3.964
62	1.564	1.664	1.764	1.854	1.954	2.054	2.154	2.254	2.344	2.444	2.544	2.644	2.744	2.844	2.934	3.034	3.134	3.234	3.334	3.434	3.524	3.624	3.724	3.824	3.924
64	1.524	1.614	1.714	1.814	1.914	2.014	2.114	2.204	2.304	2.404	2.504	2.604	2.694	2.794	2.894	2.994	3.094	3.194	3.284	3.384	3.484	3.584	3.684	3.774	3.874
66	1.474	1.574	1.674	1.774	1.874	1.964	2.064	2.164	2.264	2.364	2.464	2.554	2.654	2.754	2.854	2.954	3.044	3.144	3.244	3.344	3.444	3.544	3.634	3.734	3.834
68	1.434	1.534	1.634	1.724	1.824	1.924	2.024	2.124	2.224	2.314	2.414	2.514	2.614	2.714	2.804	2.904	3.004	3.104	3.204	3.304	3.394	3.494	3.594	3.694	3.794
70	1.394	1.484	1.584	1.684	1.784	1.884	1.984	2.074	2.174	2.274	2.374	2.474	2.564	2.664	2.764	2.864	2.964	3.064	3.154	3.254	3.354	3.454	3.554	3.654	3.744
72	1.344	1.444	1.544	1.644	1.744	1.834	1.934	2.034	2.134	2.234	2.334	2.424	2.524	2.624	2.724	2.824	2.914	3.014	3.114	3.214	3.314	3.414	3.504	3.604	3.704
74	1.304	1.404	1.504	1.594	1.694	1.794	1.894	1.994	2.094	2.184	2.284	2.384	2.484	2.584	2.684	2.774	2.874	2.974	3.074	3.174	3.264	3.364	3.464	3.564	3.664

*FVC values are given in litres. The values listed here reflect the FVC as listed in Table 5-3a minus 0.676 L (95% confidence interval). Adapted from Crapo et al.[2]

APPENDIX B

Pulmonary Function Table V

Predicted Normal Forced Expiratory Volume in the First Second (FEV_1) in Litres for Men*

Age	Height (cm)																								
	146	148	150	152	154	156	158	160	162	164	166	168	170	172	174	176	178	180	182	184	186	188	190	192	194
18	3.42	3.50	3.58	3.66	3.75	3.83	3.91	3.99	4.08	4.16	4.24	4.33	4.41	4.49	4.57	4.66	4.74	4.82	4.91	4.99	5.07	5.15	5.24	5.32	5.40
20	3.37	3.45	3.53	3.61	3.70	3.78	3.86	3.95	4.03	4.11	4.19	4.28	4.36	4.44	4.53	4.61	4.69	4.77	4.86	4.94	5.02	5.11	5.19	5.27	5.35
22	3.32	3.40	3.48	3.57	3.65	3.73	3.81	3.90	3.98	4.06	4.15	4.23	4.31	4.39	4.48	4.56	4.64	4.73	4.81	4.89	4.97	5.05	5.14	5.22	5.30
24	3.27	3.35	3.43	3.52	3.60	3.68	3.77	3.85	3.93	4.01	4.10	4.18	4.26	4.35	4.43	4.51	4.59	4.68	4.76	4.84	4.92	5.01	5.09	5.17	5.26
26	3.22	3.30	3.39	3.47	3.55	3.63	3.72	3.80	3.88	3.97	4.05	4.13	4.21	4.30	4.38	4.46	4.54	4.63	4.71	4.79	4.88	4.90	5.04	5.12	5.21
28	3.17	3.25	3.34	3.42	3.50	3.59	3.67	3.75	3.83	3.92	4.00	4.08	4.16	4.25	4.33	4.41	4.50	4.58	4.66	4.74	4.83	4.91	4.99	5.08	5.16
30	3.12	3.21	3.29	3.37	3.45	3.54	3.62	3.70	3.78	3.87	3.95	4.03	4.12	4.20	4.28	4.36	4.45	4.53	4.61	4.70	4.78	4.86	4.94	5.03	5.11
32	3.07	3.16	3.24	3.32	3.40	3.49	3.57	3.65	3.74	3.82	3.90	3.98	4.07	4.15	4.23	4.32	4.40	4.48	4.56	4.65	4.73	4.81	4.90	4.98	5.06
34	3.02	3.11	3.19	3.27	3.36	3.44	3.52	3.60	3.69	3.77	3.85	3.94	4.02	4.10	4.18	4.27	4.35	4.43	4.52	4.60	4.68	4.76	4.85	4.93	5.01
36	2.98	3.06	3.14	3.22	3.31	3.39	3.47	3.56	3.64	3.72	3.80	3.89	3.97	4.05	4.14	4.22	4.30	4.38	4.47	4.55	4.63	4.71	4.80	4.88	4.96
38	2.93	3.01	3.09	3.18	3.26	3.34	3.42	3.51	3.59	3.67	3.76	3.84	3.92	4.00	4.09	4.17	4.25	4.33	4.42	4.50	4.58	4.67	4.75	4.83	4.91
40	2.88	2.96	3.04	3.13	3.21	3.29	3.38	3.46	3.54	3.62	3.71	3.79	3.87	3.95	4.04	4.12	4.20	4.29	4.37	4.45	4.53	4.62	4.70	4.78	4.87
42	2.83	2.91	3.00	3.08	3.16	3.24	3.33	3.41	3.49	3.57	3.66	3.74	3.82	3.91	3.99	4.07	4.15	4.24	4.32	4.40	4.49	4.57	4.65	4.73	4.82
44	2.78	2.86	2.95	3.03	3.11	3.19	3.28	3.36	3.44	3.53	3.61	3.69	3.77	3.86	3.94	4.02	4.11	4.19	4.27	4.35	4.44	4.52	4.60	4.69	4.77
46	2.73	2.81	2.90	2.98	3.06	3.15	3.23	3.31	3.39	3.48	3.56	3.64	3.73	3.81	3.89	3.97	4.06	4.14	4.22	4.31	4.39	4.47	4.55	4.64	4.72
48	2.68	2.77	2.85	2.93	3.01	3.10	3.18	3.26	3.35	3.43	3.51	3.59	3.68	3.76	3.84	3.93	4.01	4.09	4.17	4.25	4.34	4.42	4.50	4.59	4.67
50	2.63	2.72	2.80	2.88	2.97	3.05	3.13	3.21	3.30	3.38	3.46	3.55	3.63	3.71	3.79	3.88	3.96	4.04	4.12	4.21	4.29	4.37	4.46	4.54	4.62
52	2.59	2.67	2.75	2.83	2.92	3.00	3.08	3.17	3.25	3.33	3.41	3.50	3.58	3.66	3.74	3.83	3.91	3.99	4.08	4.16	4.24	4.32	4.41	4.49	4.57
54	2.54	2.62	2.70	2.79	2.87	2.95	3.03	3.12	3.20	3.28	3.36	3.45	3.53	3.61	3.70	3.78	3.86	3.94	4.03	4.11	4.19	4.28	4.36	4.44	4.52
56	2.49	2.57	2.65	2.74	2.82	2.90	2.98	3.07	3.15	3.23	3.32	3.40	3.48	3.56	3.65	3.73	3.81	3.90	3.98	4.06	4.14	4.23	4.31	4.39	4.48
58	2.44	2.52	2.60	2.69	2.77	2.85	2.94	3.02	3.10	3.18	3.27	3.35	3.43	3.52	3.60	3.68	3.76	3.85	3.93	4.01	4.10	4.18	4.26	4.34	4.43
60	2.39	2.47	2.55	2.64	2.72	2.80	2.89	2.97	3.05	3.14	3.22	3.30	3.38	3.47	3.55	3.63	3.72	3.80	3.88	3.96	4.05	4.13	4.21	4.29	4.38
62	2.34	2.42	2.51	2.59	2.67	2.76	2.84	2.92	3.00	3.09	3.17	3.25	3.34	3.42	3.50	3.58	3.67	3.75	3.83	3.91	4.00	4.08	4.16	4.25	4.33
64	2.29	2.38	2.46	2.54	2.62	2.71	2.79	2.87	2.96	3.04	3.12	3.20	3.29	3.37	3.45	3.53	3.62	3.70	3.78	3.87	3.95	4.03	4.11	4.20	4.28
66	2.24	2.33	2.41	2.49	2.58	2.66	2.74	2.82	2.91	2.99	3.07	3.15	3.24	3.32	3.40	3.49	3.57	3.65	3.73	3.82	3.90	3.98	4.07	4.15	4.23
68	2.20	2.28	2.36	2.44	2.53	2.61	2.69	2.77	2.86	2.94	3.02	3.11	3.19	3.27	3.35	3.44	3.52	3.60	3.69	3.77	3.85	3.93	4.02	4.10	4.18
70	2.15	2.23	2.31	2.39	2.48	2.56	2.64	2.73	2.81	2.89	2.97	3.06	3.14	3.22	3.31	3.39	3.47	3.55	3.64	3.72	3.80	3.89	3.97	4.05	4.13
72	2.10	2.18	2.26	2.35	2.43	2.51	2.59	2.68	2.76	2.84	2.93	3.01	3.09	3.17	3.26	3.34	3.42	3.51	3.59	3.67	3.75	3.84	3.92	4.00	4.08
74	2.05	2.13	2.21	2.30	2.38	2.46	2.55	2.63	2.71	2.79	2.88	2.96	3.04	3.13	3.21	3.29	3.37	3.46	3.54	3.62	3.70	3.79	3.87	3.95	4.04

*FEV_1 in litres = 0.0414 H – 0.0244 A – 2.190, R^2 = 0.64; SEE = 0.486; 95% confidence interval = 0.842. Definitions of abbreviations: R^2 = coefficient of determination; SEE = standard error of estimate; H = height in cm; A = age in years. BTPS = body temperature, ambient pressure, and saturated with water vapour at these conditions. Adapted from Crapo et al.[2]

APPENDIX B

Pulmonary Function Table VI

Predicted Lower Limit of Normal Forced Expiratory Volume in the First Second (FEV_1) for Men*

Age	Height (cm)																								
	146	148	150	152	154	156	158	160	162	164	166	168	170	172	174	176	178	180	182	184	186	188	190	192	194
18	2.578	2.658	2.738	2.818	2.908	2.988	3.068	3.148	3.238	3.318	3.398	3.488	3.568	3.648	3.728	3.818	3.898	3.978	4.068	4.148	4.228	4.308	4.398	4.478	4.558
20	2.528	2.608	2.688	2.768	2.858	2.938	3.018	3.108	3.188	3.268	3.348	3.438	3.518	3.598	3.688	3.768	3.848	3.928	4.018	4.098	4.178	4.268	4.348	4.428	4.508
22	2.478	2.558	2.638	2.728	2.808	2.888	2.968	3.058	3.138	3.218	3.308	3.388	3.468	3.548	3.638	3.718	3.798	3.888	3.968	4.048	4.128	4.208	4.298	4.378	4.458
24	2.428	2.508	2.588	2.678	2.758	2.838	2.928	3.008	3.088	3.168	3.258	3.338	3.418	3.508	3.588	3.668	3.748	3.838	3.918	3.998	4.078	4.168	4.248	4.328	4.418
26	2.378	2.458	2.548	2.628	2.708	2.788	2.878	2.958	3.038	3.128	3.208	3.288	3.368	3.458	3.538	3.618	3.698	3.788	3.868	3.948	4.038	4.058	4.198	4.278	4.368
28	2.328	2.408	2.498	2.578	2.658	2.748	2.828	2.908	2.988	3.078	3.158	3.238	3.318	3.408	3.488	3.568	3.658	3.738	3.818	3.898	3.988	4.068	4.148	4.238	4.318
30	2.278	2.368	2.448	2.528	2.608	2.698	2.778	2.858	2.938	3.028	3.108	3.188	3.278	3.358	3.438	3.518	3.608	3.688	3.768	3.858	3.938	4.018	4.098	4.188	4.268
32	2.228	2.318	2.398	2.478	2.558	2.648	2.728	2.808	2.898	2.978	3.058	3.138	3.228	3.308	3.388	3.478	3.558	3.638	3.718	3.808	3.888	3.968	4.058	4.138	4.218
34	2.178	2.268	2.348	2.428	2.518	2.598	2.678	2.758	2.848	2.928	3.008	3.098	3.178	3.258	3.338	3.428	3.508	3.588	3.678	3.758	3.838	3.918	4.008	4.088	4.168
36	2.138	2.218	2.298	2.378	2.468	2.548	2.628	2.718	2.798	2.878	2.958	3.048	3.128	3.208	3.298	3.378	3.458	3.538	3.628	3.708	3.788	3.868	3.958	4.038	4.118
38	2.088	2.168	2.248	2.338	2.418	2.498	2.578	2.668	2.748	2.828	2.918	2.998	3.078	3.158	3.248	3.328	3.408	3.488	3.578	3.658	3.738	3.828	3.908	3.988	4.068
40	2.038	2.118	2.198	2.288	2.368	2.448	2.538	2.618	2.698	2.778	2.868	2.948	3.028	3.108	3.198	3.278	3.358	3.448	3.528	3.608	3.688	3.778	3.858	3.938	4.028
42	1.988	2.068	2.158	2.238	2.318	2.398	2.488	2.568	2.648	2.728	2.818	2.898	2.978	3.068	3.148	3.228	3.308	3.398	3.478	3.558	3.648	3.728	3.808	3.888	3.978
44	1.938	2.018	2.108	2.188	2.268	2.348	2.438	2.518	2.598	2.688	2.768	2.848	2.928	3.018	3.098	3.178	3.268	3.348	3.428	3.508	3.598	3.678	3.758	3.848	3.928
46	1.888	1.968	2.058	2.138	2.218	2.308	2.388	2.468	2.548	2.638	2.718	2.798	2.888	2.968	3.048	3.128	3.218	3.298	3.378	3.468	3.548	3.628	3.708	3.798	3.878
48	1.838	1.928	2.008	2.088	2.168	2.258	2.338	2.418	2.508	2.588	2.668	2.748	2.838	2.918	2.998	3.088	3.168	3.248	3.328	3.408	3.498	3.578	3.658	3.748	3.828
50	1.788	1.878	1.958	2.038	2.128	2.208	2.288	2.368	2.458	2.538	2.618	2.708	2.788	2.868	2.948	3.038	3.118	3.198	3.278	3.368	3.448	3.528	3.618	3.698	3.778
52	1.748	1.828	1.908	1.988	2.078	2.158	2.238	2.328	2.408	2.488	2.568	2.658	2.738	2.818	2.898	2.988	3.068	3.148	3.238	3.318	3.398	3.478	3.568	3.648	3.728
54	1.698	1.778	1.858	1.948	2.028	2.108	2.188	2.278	2.358	2.438	2.518	2.608	2.688	2.768	2.858	2.938	3.018	3.098	3.188	3.268	3.348	3.438	3.518	3.598	3.678
56	1.648	1.728	1.808	1.898	1.978	2.058	2.138	2.228	2.308	2.388	2.478	2.558	2.638	2.718	2.808	2.888	2.968	3.058	3.138	3.218	3.298	3.388	3.468	3.548	3.638
58	1.598	1.678	1.758	1.848	1.928	2.008	2.098	2.178	2.258	2.338	2.428	2.508	2.588	2.678	2.758	2.838	2.918	3.008	3.088	3.168	3.258	3.338	3.418	3.498	3.588
60	1.548	1.628	1.708	1.798	1.878	1.958	2.048	2.128	2.208	2.298	2.378	2.458	2.538	2.628	2.708	2.788	2.878	2.958	3.038	3.118	3.208	3.288	3.368	3.448	3.538
62	1.498	1.578	1.668	1.748	1.828	1.918	1.998	2.078	2.158	2.248	2.328	2.408	2.498	2.578	2.658	2.738	2.828	2.908	2.988	3.068	3.158	3.238	3.318	3.408	3.488
64	1.448	1.538	1.618	1.698	1.778	1.868	1.948	2.028	2.118	2.198	2.278	2.358	2.448	2.528	2.608	2.688	2.778	2.858	2.938	3.028	3.108	3.188	3.268	3.358	3.438
66	1.398	1.488	1.568	1.648	1.738	1.818	1.898	1.978	2.068	2.148	2.228	2.308	2.398	2.478	2.558	2.648	2.728	2.808	2.888	2.978	3.058	3.138	3.228	3.308	3.388
68	1.358	1.438	1.518	1.598	1.688	1.768	1.848	1.928	2.018	2.098	2.178	2.268	2.348	2.428	2.508	2.598	2.678	2.758	2.848	2.928	3.008	3.088	3.178	3.258	3.338
70	1.308	1.388	1.468	1.548	1.638	1.718	1.798	1.888	1.968	2.048	2.128	2.218	2.298	2.378	2.468	2.548	2.628	2.708	2.798	2.878	2.958	3.048	3.128	3.208	3.288
72	1.258	1.338	1.418	1.508	1.588	1.668	1.748	1.838	1.918	1.998	2.088	2.168	2.248	2.328	2.418	2.498	2.578	2.668	2.748	2.828	2.908	2.998	3.078	3.158	3.238
74	1.208	1.288	1.368	1.458	1.538	1.618	1.708	1.788	1.868	1.948	2.038	2.118	2.198	2.288	2.368	2.448	2.528	2.618	2.698	2.778	2.858	2.948	3.028	3.108	3.198

*FEV_1 values are given in litres. The values listed here reflect the FEV_1 as listed in Table 5-4a minus 0.842 L (95% confidence interval). Adapted from Crapo et al.[2]

APPENDIX B

Pulmonary Function Table VII

Predicted Normal Forced Expiratory Volume in the First Second (FEV_1) in Litres for Women*

Age	Height (cm)																								
	146	148	150	152	154	156	158	160	162	164	166	168	170	172	174	176	178	180	182	184	186	188	190	192	194
18	2.96	3.02	3.09	3.16	3.23	3.30	3.37	3.43	3.50	3.57	3.64	3.71	3.78	3.85	3.91	3.98	4.05	4.12	4.19	4.26	4.32	4.39	4.46	4.53	4.60
20	2.91	2.97	3.04	3.11	3.18	3.25	3.32	3.38	3.45	3.52	3.59	3.66	3.73	3.79	3.86	3.93	4.00	4.07	4.14	4.20	4.27	4.34	4.41	4.48	4.55
22	2.85	2.92	2.99	3.06	3.13	3.20	3.26	3.33	3.40	3.47	3.54	3.61	3.67	3.74	3.81	3.88	3.95	4.02	4.09	4.15	4.22	4.29	4.36	4.43	4.50
24	2.80	2.87	2.94	3.01	3.08	3.15	3.21	3.28	3.35	3.42	3.49	3.56	3.62	3.69	3.76	3.83	3.90	3.97	4.03	4.10	4.17	4.24	4.31	4.38	4.44
26	2.75	2.82	2.89	2.96	3.03	3.09	3.16	3.23	3.30	3.37	3.44	3.50	3.57	3.64	3.71	3.78	3.85	3.91	3.98	4.05	4.12	4.19	4.26	4.33	4.39
28	2.70	2.77	2.84	2.91	2.97	3.04	3.11	3.18	3.25	3.32	3.39	3.45	3.52	3.59	3.66	3.73	3.80	3.86	3.93	4.00	4.07	4.14	4.21	4.27	4.34
30	2.65	2.72	2.79	2.86	2.92	2.99	3.06	3.13	3.20	3.27	3.33	3.40	3.47	3.54	3.61	3.68	3.74	3.81	3.88	3.95	4.02	4.09	4.15	4.22	4.29
32	2.60	2.67	2.74	2.80	2.87	2.94	3.01	3.08	3.15	3.21	3.28	3.35	3.42	3.49	3.56	3.63	3.69	3.76	3.83	3.90	3.97	4.04	4.10	4.17	4.24
34	2.55	2.62	2.68	2.75	2.82	2.89	2.96	3.03	3.10	3.16	3.23	3.30	3.37	3.44	3.51	3.57	3.64	3.71	3.78	3.85	3.92	3.98	4.05	4.12	4.19
36	2.50	2.57	2.63	2.70	2.77	2.84	2.91	2.98	3.04	3.11	3.18	3.25	3.32	3.39	3.45	3.52	3.59	3.66	3.73	3.80	3.87	3.93	4.00	4.07	4.14
38	2.45	2.51	2.58	2.65	2.72	2.79	2.86	2.92	2.99	3.06	3.13	3.20	3.27	3.34	3.40	3.47	3.54	3.61	3.68	3.75	3.81	3.88	3.95	4.02	4.09
40	2.40	2.46	2.53	2.60	2.67	2.74	2.81	2.87	2.94	3.01	3.08	3.15	3.22	3.28	3.35	3.42	3.49	3.56	3.63	3.69	3.76	3.83	3.90	3.97	4.04
42	2.34	2.41	2.48	2.55	2.62	2.69	2.75	2.82	2.89	2.96	3.03	3.10	3.17	3.23	3.30	3.37	3.44	3.51	3.58	3.64	3.71	3.78	3.85	3.92	3.99
44	2.29	2.36	2.43	2.50	2.57	2.64	2.70	2.77	2.84	2.91	2.98	3.05	3.11	3.18	3.25	3.32	3.39	3.46	3.52	3.59	3.66	3.73	3.80	3.87	3.93
46	2.24	2.31	2.38	2.45	2.52	2.58	2.65	2.72	2.79	2.86	2.93	2.99	3.06	3.13	3.20	3.27	3.34	3.41	3.47	3.54	3.61	3.68	3.75	3.82	3.88
48	2.19	2.26	2.33	2.40	2.46	2.53	2.60	2.67	2.74	2.81	2.88	2.94	3.01	3.08	3.15	3.22	3.29	3.35	3.42	3.49	3.56	3.63	3.70	3.76	3.83
50	2.14	2.21	2.28	2.35	2.41	2.48	2.55	2.62	2.69	2.76	2.82	2.89	2.96	3.03	3.10	3.17	3.23	3.30	3.37	3.44	3.51	3.58	3.65	3.71	3.78
52	2.09	2.16	2.23	2.29	2.36	2.43	2.50	2.57	2.64	2.70	2.77	2.84	2.91	2.98	3.05	3.12	3.18	3.25	3.32	3.39	3.46	3.53	3.59	3.66	3.73
54	2.04	2.11	2.18	2.24	2.31	2.38	2.45	2.52	2.59	2.65	2.72	2.79	3.86	2.93	3.00	3.06	3.13	3.20	3.27	3.34	3.41	3.47	3.54	3.61	3.68
56	1.99	2.06	2.12	2.19	2.26	2.33	2.40	2.47	2.53	2.60	2.67	2.74	2.81	2.88	2.94	3.01	3.08	3.15	3.22	3.29	3.36	3.42	3.49	3.56	3.63
58	1.94	2.00	2.07	2.14	2.21	2.28	2.35	2.42	2.48	2.55	2.62	2.69	2.76	2.83	2.89	2.96	3.03	3.10	3.17	3.24	3.30	3.37	3.44	3.51	3.58
60	1.89	1.95	2.02	2.09	2.16	2.23	2.30	2.36	2.43	2.50	2.57	2.64	2.71	2.77	2.84	2.91	2.98	3.05	3.12	3.18	3.25	3.32	3.39	3.46	3.53
62	1.83	1.90	1.97	2.04	2.11	2.18	2.24	2.31	2.38	2.45	2.52	2.59	2.66	2.72	2.79	2.86	2.93	3.00	3.07	3.13	3.20	3.27	3.34	3.41	3.48
64	1.78	1.85	1.92	1.99	2.06	2.13	2.19	2.26	2.33	2.40	2.47	2.54	2.60	2.67	2.74	2.81	2.88	2.95	3.01	3.08	3.15	3.22	3.29	3.36	3.42
66	1.73	1.80	1.87	1.94	2.01	2.07	2.14	2.21	2.28	2.35	2.42	2.48	2.55	2.62	2.69	2.76	2.83	2.90	2.96	3.03	3.10	3.17	3.24	3.31	3.37
68	1.68	1.75	1.82	1.89	1.95	2.02	2.09	2.16	2.23	2.30	2.37	2.43	2.50	2.57	2.64	2.71	2.78	2.84	2.91	2.98	3.05	3.12	3.19	3.25	3.32
70	1.63	1.70	1.77	1.84	1.90	1.97	2.04	2.11	2.18	2.25	2.31	2.38	2.45	2.52	2.59	2.66	2.72	2.79	2.86	2.93	3.00	3.07	3.14	3.20	3.27
72	1.58	1.65	1.72	1.78	1.85	1.92	1.99	2.06	2.13	2.19	2.26	2.33	2.40	2.47	2.54	2.61	2.67	2.74	2.81	2.88	2.95	3.02	3.08	3.15	3.22
74	1.53	1.60	1.67	1.73	1.80	1.87	1.94	2.01	2.08	2.14	2.21	2.28	2.35	2.42	2.49	2.55	2.62	2.69	2.76	2.83	2.90	2.96	3.03	3.10	3.17

*FEV_1 in litres = 0.0342 H – 0.0225 A – 1.578, R^2 = 0.80; SEE = 0.326; 95% confidence interval = 0.561. Definitions of abbreviations: R^2 = coefficient of determination; SEE = standard error of estimate; H = height in cm; A = age in years. BTPS = body temperature, ambient pressure, and saturated with water vapour at these conditions. Adapted from Crapo et al.[2]

APPENDIX B

Pulmonary Function Table VIII

Predicted Lower Limit of Normal Forced Expiratory Volume in the First Second (FEV_1) for Women*

Age	Height (cm)																							
	146	148	150	152	154	156	158	160	162	164	166	168	170	172	174	176	178	180	182	184	186	188	190	192	194
18	2.399	2.459	2.529	2.599	2.669	2.739	2.809	2.869	2.939	3.009	3.079	3.149	3.219	3.289	3.349	3.419	3.489	3.559	3.629	3.699	3.759	3.829	3.899	3.969	4.039
20	2.349	2.409	2.479	2.549	2.619	2.689	2.759	2.819	2.889	2.959	3.029	3.099	3.169	3.229	3.299	3.369	3.439	3.509	3.579	3.639	3.709	3.779	3.849	3.919	3.989
22	2.289	2.359	2.429	2.499	2.569	2.639	2.699	2.769	2.839	2.909	2.979	3.049	3.109	3.179	3.249	3.319	3.389	3.459	3.529	3.589	3.659	3.729	3.799	3.869	3.939
24	2.239	2.309	2.379	2.449	2.519	2.589	2.649	2.719	2.789	2.859	2.929	2.999	3.059	3.129	3.199	3.269	3.339	3.409	3.469	3.539	3.609	3.679	3.749	3.819	3.879
26	2.189	2.259	2.329	2.399	2.469	2.529	2.599	2.669	2.739	2.809	2.879	2.939	3.009	3.079	3.149	3.219	3.289	3.349	3.419	3.489	3.559	3.629	3.699	3.769	3.829
28	2.139	2.209	2.279	2.349	2.409	2.479	2.549	2.619	2.689	2.759	2.829	2.889	2.959	3.029	3.099	3.169	3.239	3.299	3.369	3.439	3.509	3.579	3.649	3.709	3.779
30	2.089	2.156	2.229	2.299	2.359	2.429	2.499	2.569	2.639	2.709	2.769	2.839	2.909	2.979	3.049	3.119	3.179	3.249	3.319	3.389	3.459	3.529	3.589	3.659	3.729
32	2.039	2.109	2.179	2.239	2.309	2.379	2.449	2.519	2.589	2.649	2.719	2.789	2.859	2.929	2.999	3.069	3.129	3.199	3.269	3.339	3.409	3.479	3.539	3.609	3.679
34	1.989	2.059	2.119	2.189	2.259	2.329	2.399	2.469	2.539	2.599	2.669	2.739	2.809	2.879	2.949	3.009	3.079	3.149	3.219	3.289	3.359	3.419	3.489	3.559	3.629
36	1.939	2.009	2.069	2.139	2.209	2.279	2.349	2.419	2.479	2.549	2.619	2.689	2.759	2.829	2.889	2.959	3.029	3.099	3.169	3.239	3.309	3.369	3.439	3.509	3.579
38	1.889	1.949	2.019	2.089	2.159	2.229	2.299	2.359	2.429	2.499	2.569	2.639	2.709	2.779	2.839	2.909	2.979	3.049	3.119	3.189	3.249	3.319	3.389	3.459	3.529
40	1.839	1.899	1.969	2.039	2.109	2.179	2.249	2.309	2.379	2.449	2.519	2.589	2.659	2.719	2.789	2.859	2.929	2.999	3.069	3.129	3.199	3.269	3.339	3.409	3.479
42	1.779	1.849	1.919	1.989	2.059	2.129	2.189	2.259	2.329	2.399	2.469	2.539	2.609	2.669	2.739	2.809	2.879	2.949	3.019	3.079	3.149	3.219	3.289	3.359	3.429
44	1.729	1.799	1.869	1.939	2.009	2.079	2.139	2.209	2.279	2.349	2.419	2.489	2.549	2.619	2.689	2.759	2.829	2.899	2.959	3.029	3.099	3.169	3.239	3.309	3.369
46	1.679	1.749	1.819	1.889	1.959	2.019	2.089	2.159	2.229	2.299	2.369	2.429	2.499	2.569	2.639	2.709	2.779	2.849	2.909	2.979	3.049	3.119	3.189	3.259	3.319
48	1.629	1.699	1.769	1.839	1.899	1.969	2.039	2.109	2.179	2.249	2.319	2.379	2.449	2.519	2.589	2.659	2.729	2.789	2.859	2.929	2.999	3.069	3.139	3.199	3.269
50	1.579	1.649	1.719	1.789	1.849	1.919	1.989	2.059	2.129	2.199	2.259	2.329	2.399	2.469	2.539	2.609	2.669	2.739	2.809	2.879	2.949	3.019	3.089	3.149	3.219
52	1.529	1.599	1.669	1.729	1.799	1.869	1.939	2.009	2.079	2.139	2.209	2.279	2.349	2.419	2.489	2.559	2.619	2.689	2.759	2.829	2.899	2.969	3.029	3.099	3.169
54	1.479	1.549	1.619	1.679	1.749	1.819	1.889	1.959	2.029	2.089	2.159	2.229	3.299	2.369	2.439	2.499	2.569	2.639	2.709	2.779	2.849	2.909	2.979	3.049	3.119
56	1.429	1.499	1.559	1.629	1.699	1.769	1.839	1.909	1.969	2.039	2.109	2.179	2.249	2.319	2.379	2.449	2.519	2.589	2.659	2.729	2.799	2.859	2.929	2.999	3.069
58	1.379	1.439	1.509	1.579	1.649	1.719	1.789	1.859	1.919	1.989	2.059	2.129	2.199	2.269	2.329	2.399	2.469	2.539	2.609	2.679	2.739	2.809	2.879	2.949	3.019
60	1.329	1.389	1.459	1.529	1.599	1.669	1.739	1.799	1.869	1.939	2.009	2.079	2.149	2.209	2.279	2.349	2.419	2.489	2.559	2.619	2.689	2.759	2.829	2.899	2.969
62	1.269	1.339	1.409	1.479	1.549	1.619	1.679	1.749	1.819	1.889	1.959	2.029	2.099	2.159	2.229	2.299	2.369	2.439	2.509	2.569	2.639	2.709	2.779	2.849	2.919
64	1.219	1.289	1.359	1.429	1.499	1.569	1.629	1.699	1.769	1.839	1.909	1.979	2.039	2.109	2.179	2.249	2.319	2.389	2.449	2.519	2.589	2.659	2.729	2.799	2.859
66	1.169	1.239	1.309	1.379	1.449	1.509	1.579	1.649	1.719	1.789	1.859	1.919	1.989	2.059	2.129	2.199	2.269	2.339	2.399	2.469	2.539	2.609	2.679	2.749	2.809
68	1.119	1.189	1.259	1.329	1.389	1.459	1.529	1.599	1.669	1.739	1.809	1.869	1.939	2.009	2.079	2.149	2.219	2.279	2.349	2.419	2.489	2.559	2.629	2.689	2.759
70	1.069	1.139	1.209	1.279	1.339	1.409	1.479	1.549	1.619	1.689	1.749	1.819	1.889	1.959	2.029	2.099	2.159	2.229	2.299	2.369	2.439	2.509	2.579	2.639	2.709
72	1.019	1.089	1.159	1.219	1.289	1.359	1.429	1.499	1.569	1.629	1.699	1.769	1.839	1.909	1.979	2.049	2.109	2.179	2.249	2.319	2.389	2.459	2.519	2.589	2.659
74	0.969	1.039	1.109	1.169	1.239	1.309	1.379	1.449	1.519	1.579	1.649	1.719	1.789	1.859	1.929	1.989	2.059	2.129	2.199	2.269	2.339	2.399	2.469	2.539	2.609

*FEV_1 values are given in litres. The values listed here reflect the FEV_1 as listed in Table 5-5a minus 0.561 L (95% confidence interval). Adapted from Crapo et al.[2]

APPENDIX B

Pulmonary Function Table IX

Predicted Normal Diffusing Capacity for Carbon Monoxide (Dco) for Men (STPD)*

Age	Height (cm)																							
	146	148	150	152	154	156	158	160	162	164	166	168	170	172	174	176	178	180	182	184	186	188	190	192	194
18	29.8	30.6	31.4	32.2	33.1	33.9	34.7	35.5	36.3	37.1	38.0	38.8	39.6	40.4	41.2	42.1	42.9	43.7	44.5	45.4	46.2	47.0	47.8	48.6	49.4
20	29.3	30.2	31.0	31.8	32.6	33.4	34.3	35.1	35.9	36.7	37.5	38.4	39.2	40.0	40.8	41.6	42.5	43.3	44.1	44.9	45.7	46.6	47.4	48.2	49.0
22	28.9	29.7	30.6	31.4	32.2	33.0	33.8	34.7	35.5	36.3	37.1	37.9	38.8	39.6	40.4	41.2	42.0	42.9	43.7	44.5	45.3	46.1	47.0	47.8	48.6
24	28.5	29.3	30.1	31.0	31.8	32.6	33.4	34.2	35.1	35.9	36.7	37.5	38.3	39.2	40.0	40.8	41.6	42.4	43.3	44.1	44.9	45.7	46.5	47.4	48.2
26	28.1	28.9	29.7	30.5	31.4	32.2	33.0	33.8	34.6	35.5	36.3	37.1	37.9	38.7	39.6	40.4	41.2	42.0	42.8	43.7	44.5	45.3	46.1	46.9	47.8
28	27.7	28.5	29.3	30.1	30.9	31.8	32.6	33.4	34.2	35.0	35.9	36.7	37.5	38.3	39.1	40.0	40.8	41.6	42.4	43.2	44.1	44.9	45.7	46.5	47.3
30	27.2	28.1	28.9	29.7	30.5	31.3	32.2	33.0	33.8	34.6	35.4	36.3	37.1	37.9	38.7	39.6	40.4	41.2	42.0	42.8	43.6	44.5	45.3	46.1	46.9
32	26.8	27.6	28.5	29.3	30.1	30.9	31.7	32.6	33.4	34.2	35.0	35.8	36.7	37.5	38.3	39.1	39.9	40.8	41.6	42.4	43.2	44.1	44.9	45.7	46.5
34	26.4	27.2	28.1	28.9	29.7	30.5	31.3	32.1	33.0	33.8	34.6	35.4	36.2	37.1	37.9	38.7	39.5	40.4	41.2	42.0	42.8	43.6	44.4	45.3	46.1
36	26.0	26.8	27.6	28.4	29.3	30.1	30.9	31.7	32.5	33.4	34.2	35.0	35.8	36.6	37.5	38.3	39.1	39.9	40.7	41.6	42.4	43.2	44.0	44.8	45.7
38	25.6	26.4	27.2	28.0	28.8	29.7	30.5	31.3	32.1	32.9	33.8	34.6	35.4	36.2	37.0	37.9	38.7	39.5	40.3	41.1	42.0	42.8	43.6	44.4	45.2
40	25.1	26.0	26.8	27.6	28.4	29.2	30.1	30.9	31.7	32.5	33.3	34.2	35.0	35.8	36.6	37.4	38.3	39.1	39.9	40.7	41.5	42.4	43.2	44.0	44.8
42	24.7	25.5	26.4	27.2	28.0	28.8	29.6	30.5	31.3	32.1	32.9	33.7	34.6	35.4	36.2	37.0	37.8	38.7	39.5	40.3	41.1	41.9	42.8	43.6	44.4
44	24.3	25.1	25.9	26.8	27.6	28.4	29.2	30.0	30.9	31.7	32.5	33.3	34.1	35.0	35.8	36.6	37.4	38.2	39.1	39.9	40.7	41.5	42.3	43.2	44.0
46	23.9	24.7	25.5	26.3	27.2	28.0	28.8	29.6	30.4	31.3	32.1	32.9	33.7	34.6	35.4	36.2	37.0	37.8	38.6	39.5	40.3	41.1	41.9	42.7	43.6
48	23.5	24.3	25.1	25.9	26.7	27.6	28.4	29.2	30.0	30.8	31.7	32.5	33.3	34.1	34.9	35.8	36.6	37.4	38.2	39.1	39.9	40.7	41.5	42.3	43.1
50	23.1	23.9	24.7	25.5	26.3	27.1	28.0	28.8	29.6	30.4	31.2	32.1	32.9	33.7	34.5	35.4	36.2	37.0	37.8	38.6	39.4	40.3	41.1	41.9	42.7
52	22.6	23.4	24.3	25.1	25.9	26.7	27.6	28.4	29.2	30.0	30.8	31.6	32.5	33.3	34.1	34.9	35.7	36.6	37.4	38.2	39.0	39.9	40.7	41.6	42.3
54	22.2	23.0	23.8	24.7	25.5	26.3	27.1	27.9	28.8	29.6	30.4	31.2	32.0	32.9	33.7	34.5	35.3	36.1	37.0	37.8	38.6	39.4	40.2	41.1	41.9
56	21.8	22.6	23.4	24.2	25.1	25.9	26.7	27.5	28.3	29.2	30.0	30.8	31.6	32.4	33.3	34.1	34.9	35.7	36.5	37.4	38.2	39.0	39.8	40.6	41.5
58	21.4	22.2	23.0	23.8	24.6	25.5	26.3	27.1	27.9	28.7	29.6	30.4	31.2	32.0	32.8	33.7	34.5	35.3	36.1	36.9	37.8	38.6	39.4	40.2	41.0
60	20.9	21.8	22.6	23.4	24.2	25.0	25.9	26.7	27.5	28.3	29.1	30.0	30.8	31.6	32.4	33.2	34.1	34.9	35.7	36.5	37.3	38.2	39.0	39.8	40.6
62	20.5	21.3	22.2	23.0	23.8	24.6	25.4	26.3	27.1	27.9	28.7	29.5	30.4	31.2	32.0	32.8	33.6	34.5	35.3	36.1	36.9	37.7	38.6	39.4	40.2
64	20.1	20.9	21.7	22.6	23.4	24.2	25.0	25.8	26.7	27.5	28.3	29.1	29.9	30.8	31.6	32.4	33.2	34.1	34.9	35.7	36.5	37.3	38.1	39.0	39.8
66	19.7	20.5	21.3	22.1	23.0	23.8	24.6	25.4	26.2	27.1	27.9	28.7	29.5	30.4	31.2	32.0	32.8	33.6	34.4	35.3	36.1	36.9	37.7	38.6	39.4
68	19.3	20.1	20.9	21.7	22.6	23.4	24.2	25.0	25.8	26.6	27.5	28.3	29.1	29.9	30.7	31.6	32.4	38.2	34.0	34.9	35.7	36.5	37.3	38.1	38.9
70	18.8	19.7	20.5	21.3	22.1	22.9	23.8	24.6	25.4	26.2	27.0	27.9	28.7	29.5	30.3	31.1	32.0	32.8	33.6	34.4	35.2	36.1	36.9	37.7	38.5
72	18.4	19.2	20.1	20.9	21.7	22.5	23.3	24.2	25.0	25.8	26.6	27.4	28.3	29.1	29.9	30.7	31.5	32.4	33.2	34.0	34.8	35.6	36.5	37.3	38.1
74	18.0	18.8	19.6	20.5	21.3	22.1	22.9	23.7	24.6	25.4	26.2	27.0	27.8	28.7	29.5	30.3	31.1	31.9	32.8	33.6	34.4	35.2	36.0	36.9	37.7

*Dco in mL/min/mm Hg = 0.410 H – 0.210 A – 26.31. R^2 = 0.60; SEE = 4.82; 95% confidence interval = 8.2. Definitions of abbreviations: R^2 = coefficient of determination; SEE = standard error of estimate; H = height in cm; A = age in years. STPD = temperature 0°C, pressure 760 mm Hg, and dry (0 water vapour). The regression analysis has been normalized to a standard hemoglobin of 146 g/L by means of Cotes' modification of the relationship described by Roughton and Forster. Adapted from Crapo and Morris.[9]

APPENDIX B

Pulmonary Function Table X

Predicted Lower Limit of Normal Diffusing Capacity for Carbon Monoxide (Dco) for Men*

Age	Height (cm)																							
	146	148	150	152	154	156	158	160	162	164	166	168	170	172	174	176	178	180	182	184	186	188	190	192	194
18	21.6	22.4	23.2	24.0	24.9	25.7	26.5	27.3	28.1	28.9	29.8	30.6	31.4	32.2	33.0	33.9	34.7	35.5	36.3	37.2	38.0	38.8	39.6	40.4	41.2
20	21.1	22.0	22.8	23.6	24.4	25.2	26.1	26.9	27.7	28.5	29.3	30.2	31.0	31.8	32.6	33.4	34.3	35.1	35.9	36.7	37.5	38.4	39.2	40.0	40.8
22	20.7	21.5	22.4	23.2	24.0	24.8	25.6	26.5	27.3	28.1	28.9	29.7	30.6	31.4	32.2	33.0	33.8	34.7	35.5	36.3	37.1	37.9	38.8	39.6	40.4
24	20.3	21.1	21.9	22.8	23.6	24.4	25.2	26.0	26.9	27.7	28.5	29.3	30.1	31.0	31.8	32.6	33.4	34.2	35.1	35.9	36.7	37.5	38.3	39.2	40.0
26	19.9	20.7	21.5	22.3	23.2	24.0	24.8	25.6	26.4	27.3	28.1	28.9	29.7	30.5	31.4	32.2	33.0	33.8	34.6	35.5	36.3	37.1	37.9	38.7	39.6
28	19.5	20.3	21.1	21.9	22.7	23.6	24.4	25.2	26.0	26.8	27.7	28.5	29.3	30.1	30.9	31.8	32.6	33.4	34.2	35.0	35.9	36.7	37.5	38.3	39.1
30	19.0	19.9	20.7	21.5	22.3	23.1	24.0	24.8	25.6	26.4	27.2	28.1	28.9	29.7	30.5	31.4	32.2	33.0	33.8	34.6	35.4	36.3	37.1	37.9	38.7
32	18.6	19.4	20.3	21.1	21.9	22.7	23.5	24.4	25.2	26.0	26.8	27.6	28.5	29.3	30.1	30.9	31.7	32.6	33.4	34.2	35.0	35.9	36.7	37.5	38.3
34	18.2	19.0	19.9	20.7	21.5	22.3	23.1	23.9	24.8	25.6	26.4	27.2	28.0	28.9	29.7	30.5	31.3	32.2	33.0	33.8	34.6	35.4	36.2	37.1	37.9
36	17.8	18.6	19.4	20.2	21.1	21.9	22.7	23.5	24.3	25.2	26.0	26.8	27.6	28.4	29.3	30.1	30.9	31.7	32.5	33.4	34.2	35.0	35.8	36.6	37.5
38	17.4	18.2	19.0	19.8	20.6	21.5	22.3	23.1	23.9	24.7	25.6	26.4	27.2	28.0	28.8	29.7	30.5	31.3	32.1	32.9	33.8	34.6	35.4	36.2	37.0
40	16.9	17.8	18.6	19.4	20.2	21.0	21.9	22.7	23.5	24.3	25.1	26.0	26.8	27.6	28.4	29.2	30.1	30.9	31.7	32.5	33.3	34.2	35.0	35.8	36.6
42	16.5	17.3	18.2	19.0	19.8	20.6	21.4	22.3	23.1	23.9	24.7	25.5	26.4	27.2	28.0	28.8	29.6	30.5	31.3	32.1	32.9	33.7	34.6	35.4	36.2
44	16.1	16.9	17.7	18.6	19.4	20.2	21.0	21.8	22.7	23.5	24.3	25.1	25.9	26.8	27.6	28.4	29.2	30.0	30.9	31.7	32.5	33.3	34.1	35.0	35.8
46	15.7	16.5	17.3	18.1	19.0	19.8	20.6	21.4	22.2	23.1	23.9	24.7	25.5	26.4	27.2	28.0	28.8	29.6	30.4	31.3	32.1	32.9	33.7	34.5	35.4
48	15.3	16.1	16.9	17.7	18.5	19.4	20.2	21.0	21.8	22.6	23.5	24.3	25.1	25.9	26.7	27.6	28.4	29.2	30.0	30.9	31.7	32.5	33.3	34.1	34.9
50	14.9	15.7	16.5	17.3	18.1	18.9	19.8	20.6	21.4	22.2	23.0	23.9	24.7	25.5	26.3	27.2	28.0	28.8	29.6	30.4	31.2	32.1	32.9	33.7	34.5
52	14.4	15.2	16.1	16.9	17.7	18.5	19.4	20.2	21.0	21.8	22.6	23.4	24.3	25.1	25.9	26.7	27.5	28.4	29.2	30.0	30.8	31.7	32.5	33.4	34.1
54	14.0	14.8	15.6	16.5	17.3	18.1	18.9	19.7	20.6	21.4	22.2	23.0	23.8	24.7	25.5	26.3	27.1	27.9	28.8	29.6	30.4	31.2	32.0	32.9	33.7
56	13.6	14.4	15.2	16.0	16.9	17.7	18.5	19.3	20.1	21.0	21.8	22.6	23.4	24.2	25.1	25.9	26.7	27.5	28.3	29.2	30.0	30.8	31.6	32.4	33.3
58	13.2	14.0	14.8	15.6	16.4	17.3	18.1	18.9	19.7	20.5	21.4	22.2	23.0	23.8	24.6	25.5	26.3	27.1	27.9	28.7	29.6	30.4	31.2	32.0	32.8
60	12.7	13.6	14.4	15.2	16.0	16.8	17.7	18.5	19.3	20.1	20.9	21.8	22.6	23.4	24.2	25.0	25.9	26.7	27.5	28.3	29.1	30.0	30.8	31.6	32.4
62	12.3	13.1	14.0	14.8	15.6	16.4	17.2	18.1	18.9	19.7	20.5	21.3	22.2	23.0	23.8	24.6	25.4	26.3	27.1	27.9	28.7	29.5	30.4	31.2	32.0
64	11.9	12.7	13.5	14.4	15.2	16.0	16.8	17.6	18.5	19.3	20.1	20.9	21.7	22.6	23.4	24.2	25.0	25.9	26.7	27.5	28.3	29.1	29.9	30.8	31.6
66	11.5	12.3	13.1	13.9	14.8	15.6	16.4	17.2	18.0	18.9	19.7	20.5	21.3	22.2	23.0	23.8	24.6	25.4	26.2	27.1	27.9	28.7	29.5	30.4	31.2
68	11.1	11.9	12.7	13.5	14.4	15.2	16.0	16.8	17.6	18.4	19.3	20.1	20.9	21.7	22.5	23.4	24.2	30.0	25.8	26.7	27.5	28.3	29.1	29.9	30.7
70	10.6	11.5	12.3	13.1	13.9	14.7	15.6	16.4	17.2	18.0	18.8	19.7	20.5	21.3	22.1	22.9	23.8	24.6	25.4	26.2	27.0	27.9	28.7	29.5	30.3
72	10.2	11.0	11.9	12.7	13.5	14.3	15.1	16.0	16.8	17.6	18.4	19.2	20.1	20.9	21.7	22.5	23.3	24.2	25.0	25.8	26.6	27.4	28.3	29.1	29.9
74	9.8	10.6	11.4	12.3	13.1	13.9	14.7	15.5	16.4	17.2	18.0	18.8	19.6	20.5	21.3	22.1	22.9	23.7	24.6	25.4	26.2	27.0	27.8	28.7	29.5

*Dco values are given in mL/min/mm Hg. The values listed here reflect the Dco as listed in Table 5-6a minus 8.2 (95% confidence interval). Adapted from Crapo and Morris.[9]

APPENDIX B

Pulmonary Function Table XI

Predicted Normal Diffusing Capacity for Carbon Monoxide (Dco) for Women (STPD)*

Age	Height (cm)																								
	146	148	150	152	154	156	158	160	162	164	166	168	170	172	174	176	178	180	182	184	186	188	190	192	194
18	26.0	26.5	27.0	27.6	28.1	28.6	29.2	29.7	30.2	30.8	31.3	31.9	32.4	32.9	33.5	34.0	34.5	35.1	35.6	36.1	36.7	37.2	37.7	38.3	38.8
20	25.7	26.2	26.7	27.3	27.8	28.4	28.9	29.4	30.0	30.5	31.0	31.6	32.1	32.6	33.2	33.7	34.2	34.8	35.3	35.8	36.4	36.9	37.4	38.0	38.5
22	25.4	25.9	26.5	27.0	27.5	28.1	28.6	29.1	29.7	30.2	30.7	31.3	31.8	32.3	32.9	33.4	33.9	34.5	35.0	35.5	36.1	36.6	37.1	37.7	38.2
24	25.1	25.6	26.2	26.7	27.2	27.8	28.3	28.8	29.4	29.9	30.4	31.0	31.5	32.0	32.6	33.1	33.6	34.2	34.7	35.2	35.8	36.3	36.8	37.4	37.9
26	24.8	25.3	25.9	26.4	26.9	27.5	28.0	28.5	29.1	29.6	30.1	30.7	31.2	31.7	32.3	32.8	33.3	33.9	34.4	34.9	35.5	36.0	36.5	37.1	37.6
28	24.5	25.0	25.6	26.1	26.6	27.2	27.7	28.2	28.8	29.3	29.8	30.4	30.9	31.4	32.0	32.5	33.0	33.6	34.1	34.6	35.2	35.7	36.2	36.8	37.3
30	24.2	24.7	25.3	25.8	26.3	26.9	27.4	27.9	28.5	29.0	29.5	30.1	30.6	31.1	31.7	32.2	32.7	33.3	33.8	34.3	34.9	35.4	35.9	36.5	37.0
32	23.9	24.4	25.0	25.5	26.0	26.6	27.1	27.6	28.2	28.7	29.2	29.8	30.3	30.8	31.4	31.9	32.4	33.0	33.5	34.1	34.6	35.1	35.7	36.2	36.7
34	23.6	24.1	24.7	25.2	25.7	26.3	26.8	27.3	27.9	28.4	28.9	29.5	30.0	30.6	31.1	31.6	33.2	32.7	33.2	33.8	34.3	34.8	35.4	35.9	36.4
36	23.3	23.8	24.4	24.9	25.4	26.0	26.5	27.1	27.6	28.1	28.7	29.2	29.7	30.3	30.8	31.3	31.9	32.4	32.9	33.5	34.0	34.5	35.1	35.6	36.1
38	23.0	23.6	24.1	24.6	25.2	25.7	26.2	26.8	27.3	27.8	28.4	28.9	29.4	30.0	30.5	31.0	31.6	32.1	32.6	33.2	33.7	34.2	34.8	35.3	35.8
40	22.7	23.3	23.8	24.3	24.9	25.4	25.9	26.5	27.0	27.5	28.1	28.6	29.1	29.7	30.2	30.7	31.3	31.8	32.3	32.9	33.4	33.9	34.5	35.0	35.5
42	22.4	23.0	23.5	24.0	24.6	25.1	25.6	26.2	26.7	27.2	27.8	28.3	28.8	29.4	29.9	30.4	31.0	31.5	32.0	32.6	33.1	33.6	34.2	34.7	35.2
44	22.1	22.7	23.2	23.7	24.3	24.3	25.3	25.9	26.4	26.9	27.5	28.0	28.5	29.1	29.6	30.1	30.7	31.2	31.7	32.3	32.8	33.3	33.9	34.4	34.9
46	21.8	22.4	22.9	23.4	24.0	24.5	25.0	25.6	26.1	26.6	27.2	27.7	28.2	28.8	29.3	29.8	30.4	30.9	31.4	32.0	32.5	33.0	33.6	34.1	34.6
48	21.5	22.1	22.6	23.1	23.7	24.2	24.7	25.3	25.8	26.3	26.9	27.4	27.9	28.5	29.0	29.5	30.1	30.6	31.1	31.7	32.2	32.8	33.3	33.8	34.4
50	21.2	21.8	22.3	22.8	23.4	23.9	24.4	25.0	25.5	26.0	26.6	27.1	27.6	28.2	28.7	29.3	29.8	30.3	30.9	31.4	31.9	32.5	33.0	33.5	34.1
52	20.9	21.5	22.0	22.5	23.1	23.5	24.1	24.7	25.2	25.8	26.3	26.8	27.4	27.9	28.4	29.0	29.5	30.0	30.6	31.1	31.6	32.2	32.7	33.2	33.8
54	20.6	21.2	21.7	22.3	22.8	23.3	23.9	24.4	24.9	25.5	26.0	26.5	27.1	27.6	28.1	28.7	29.2	29.7	30.3	30.8	31.3	31.9	32.4	32.9	33.5
56	20.4	20.9	21.4	22.0	22.5	23.0	23.6	24.1	24.6	25.2	25.7	26.2	26.8	27.3	27.8	28.4	28.9	29.4	30.0	30.5	31.0	31.6	32.1	32.6	33.2
58	20.1	20.6	21.1	21.7	22.2	22.7	23.3	23.8	24.3	24.9	25.4	25.9	26.5	27.0	27.5	28.1	28.6	29.1	29.7	30.2	30.7	31.3	31.8	32.3	32.9
60	19.8	20.3	20.8	21.4	21.9	22.4	23.0	23.5	24.0	24.6	25.1	25.6	26.2	26.7	27.2	27.8	28.3	28.8	29.4	29.9	30.4	31.0	31.5	32.0	32.6
62	19.5	20.0	20.5	21.1	21.6	22.1	22.7	23.2	23.7	24.3	24.8	25.3	25.9	26.4	26.9	27.5	28.0	28.5	29.1	29.6	30.1	30.7	31.2	31.7	32.3
64	19.2	19.7	20.2	20.8	21.3	21.8	22.4	22.9	23.4	24.0	24.5	25.0	25.6	26.1	26.6	27.2	27.7	28.2	28.8	29.3	29.8	30.4	30.9	31.5	32.0
66	18.9	19.4	19.9	20.5	21.0	21.5	22.1	22.6	23.1	23.7	24.2	24.1	25.3	25.8	26.3	26.9	27.4	28.0	28.5	29.0	29.6	30.1	30.6	31.2	31.7
68	18.6	19.1	19.6	20.2	20.7	21.2	21.8	22.3	22.8	23.4	23.9	24.5	25.0	25.5	26.1	26.6	27.1	27.7	28.2	28.7	29.3	29.8	30.3	30.9	31.4
70	18.3	18.8	19.3	19.9	20.4	21.0	21.5	22.0	22.6	23.1	23.5	24.2	24.7	25.2	25.8	26.3	26.8	27.4	27.9	28.4	29.0	29.5	30.0	30.6	31.1
72	18.0	18.5	19.1	19.6	20.1	20.7	21.2	21.1	22.3	22.8	23.3	23.9	24.4	24.9	25.5	26.0	26.5	27.1	27.6	28.1	28.7	29.2	29.7	30.3	30.8
74	17.7	18.2	18.8	19.3	19.8	20.4	20.9	21.4	22.0	22.5	23.0	23.6	24.1	24.6	25.2	25.7	26.2	26.8	27.3	27.8	28.4	28.9	29.4	30.0	30.5

*Dco in mL/min/mm Hg = 0.267 H – 0.148 A – 10.34. R^2 = 0.60; SEE = 3.40; 95% confidence interval = 5.74. Definitions of abbreviations: R^2 = coefficient of determination; SEE = standard error of estimate; H = height in cm; A = age in years. STPD = temperature 0°C, pressure 760 mm Hg, and dry (0 water vapour). The regression analysis has been normalized to a standard hemoglobin of 125 g/L (the original equation was normalized to a standard hemoglobin of 146 g/L) by means of Cotes' modification of the relationship described in Roughton and Forster. Adapted from Crapo and Morris.[9]

APPENDIX B

Pulmonary Function Table XII

Predicted Lower Limit of Normal Diffusing Capacity for Carbon Monoxide (Dco) for Women*

Age	Height (cm)																							
	146	148	150	152	154	156	158	160	162	164	166	168	170	172	174	176	178	180	182	184	186	188	190	192	194
18	20.26	20.76	21.26	21.86	22.36	22.86	23.46	23.96	24.46	25.06	25.56	26.16	26.66	27.16	27.76	28.26	28.76	29.36	29.86	30.36	30.96	31.46	31.96	32.56	33.06
20	19.96	20.46	20.96	21.56	22.06	22.66	23.16	23.66	24.26	24.76	25.26	25.86	26.36	26.86	27.46	27.96	28.46	29.06	29.56	30.06	30.66	31.16	31.66	32.26	32.76
22	19.66	20.16	20.76	21.26	21.76	22.36	22.86	23.36	23.96	24.46	24.96	25.56	26.06	26.56	27.16	27.66	28.16	28.76	29.26	29.76	30.36	30.86	31.36	31.96	32.46
24	19.36	19.86	20.46	20.96	21.46	22.06	22.56	23.06	23.66	24.16	24.66	25.26	25.76	26.26	26.86	27.36	27.86	28.46	28.96	29.46	30.06	30.56	31.06	31.66	32.16
26	19.06	19.56	20.16	20.66	21.16	21.76	22.26	22.76	23.36	23.86	24.36	24.96	25.46	25.96	26.56	27.06	27.56	28.16	28.66	29.16	29.76	30.26	30.76	31.36	31.86
28	18.76	19.26	19.86	20.36	20.86	21.46	21.96	22.46	23.06	23.56	24.06	24.66	25.16	25.66	26.26	26.76	27.26	27.86	28.36	28.86	29.46	29.96	30.46	31.06	31.56
30	18.46	18.96	19.56	20.06	20.56	21.16	21.66	22.16	22.76	23.26	23.76	24.36	24.86	25.36	25.96	26.46	26.96	27.56	28.06	28.56	29.16	29.66	30.16	30.76	31.26
32	18.16	18.66	19.26	19.76	20.26	20.86	21.36	21.86	22.46	22.96	23.46	24.06	24.56	25.06	25.66	26.16	26.66	27.26	27.76	28.36	28.86	29.36	29.96	30.46	30.96
34	17.86	18.36	18.96	19.46	19.96	20.56	21.06	21.56	22.16	22.66	23.16	23.76	24.26	24.86	25.36	25.86	27.46	26.96	27.46	28.06	28.56	29.06	29.66	30.16	30.66
36	17.56	18.06	18.66	19.16	19.66	20.26	20.76	21.36	21.86	22.36	22.96	23.46	23.96	24.56	25.06	25.56	26.16	26.66	27.16	27.76	28.26	28.76	29.36	29.86	30.36
38	17.26	17.86	18.36	18.86	19.46	19.96	20.46	21.06	21.56	22.06	22.66	23.16	23.66	24.26	24.76	25.26	25.86	26.36	26.86	27.46	27.96	28.46	29.06	29.56	30.06
40	16.96	17.56	18.06	18.56	19.16	19.66	20.16	20.76	21.26	21.76	22.36	22.86	23.36	23.96	24.46	24.96	25.56	26.06	26.56	27.16	27.66	28.16	28.76	29.26	29.76
42	16.66	17.26	17.76	18.26	18.86	19.36	19.86	20.46	20.96	21.46	22.06	22.56	23.06	23.66	24.16	24.66	25.26	25.76	26.26	26.86	27.36	27.86	28.46	28.96	29.46
44	16.36	16.96	17.46	17.96	18.56	18.56	19.56	20.16	20.66	21.16	21.76	22.26	22.76	23.36	23.86	24.36	24.96	25.46	25.96	26.56	27.06	27.56	28.16	28.66	29.16
46	16.06	16.66	17.16	17.66	18.26	18.76	19.26	19.86	20.36	20.86	21.46	21.96	22.46	23.06	23.56	24.06	24.66	25.16	25.66	26.26	26.76	27.26	27.86	28.36	28.86
48	15.76	16.36	16.86	17.36	17.96	18.46	18.96	19.56	20.06	20.56	21.16	21.66	22.16	22.76	23.26	23.76	24.36	24.86	25.36	25.96	26.46	27.06	27.56	28.06	28.66
50	15.46	16.06	16.56	17.06	17.66	18.16	18.66	19.26	19.76	20.26	20.86	21.36	21.86	22.46	22.96	23.56	24.06	24.56	25.16	25.66	26.16	26.76	27.26	27.76	28.36
52	15.16	15.76	16.26	16.76	17.36	17.76	18.36	18.96	19.46	20.06	20.56	21.06	21.66	22.16	22.66	23.26	23.76	24.26	24.86	25.36	25.86	26.46	26.96	27.46	28.06
54	14.86	15.46	15.96	16.56	17.06	17.56	18.16	18.66	19.16	19.76	20.26	20.76	21.36	21.86	22.36	22.96	23.46	23.96	24.56	25.06	25.56	26.16	26.66	27.16	27.76
56	14.66	15.16	15.66	16.26	16.76	17.26	17.86	18.36	18.86	19.46	19.96	20.46	21.06	21.56	22.06	22.66	23.16	23.66	24.26	24.76	25.26	25.86	26.36	26.86	27.46
58	14.36	14.86	15.36	15.96	16.46	16.96	17.56	18.06	18.56	19.16	19.66	20.16	20.76	21.26	21.76	22.36	22.86	23.36	23.96	24.46	24.96	25.56	26.06	26.56	27.16
60	14.06	14.56	15.06	15.66	16.16	16.66	17.26	17.76	18.26	18.86	19.36	19.86	20.46	20.96	21.46	22.06	22.56	23.06	23.66	24.16	24.66	25.26	25.76	26.26	26.86
62	13.76	14.26	14.76	15.36	15.86	16.36	16.96	17.46	17.96	18.56	19.06	19.56	20.16	20.66	21.16	21.76	22.26	22.76	23.36	23.86	24.36	24.96	25.46	25.96	26.56
64	13.46	13.96	14.46	15.06	15.56	16.06	16.66	17.16	17.66	18.26	18.76	19.26	19.86	20.36	20.86	21.46	21.96	22.46	23.06	23.56	24.06	24.66	25.16	25.76	26.26
66	13.16	13.66	14.16	14.76	15.26	15.76	16.36	16.86	17.36	17.96	18.46	18.36	19.56	20.06	20.56	21.16	21.66	22.26	22.76	23.26	23.86	24.36	24.86	25.46	25.96
68	12.86	13.36	13.86	14.46	14.96	15.46	16.06	16.56	17.06	17.66	18.16	18.76	19.26	19.76	20.36	20.86	21.36	21.96	22.46	22.96	23.56	24.06	24.56	25.16	25.66
70	12.56	13.06	13.56	14.16	14.66	15.26	15.76	16.26	16.86	17.36	17.76	18.46	18.96	19.46	20.06	20.56	21.06	21.66	22.16	22.66	23.26	23.76	24.26	24.86	25.36
72	12.26	12.76	13.36	13.86	14.36	14.96	15.46	15.36	16.56	17.06	17.56	18.16	18.66	19.16	19.76	20.26	20.76	21.36	21.86	22.36	22.96	23.46	23.96	24.56	25.06
74	11.96	12.46	13.06	13.56	14.06	14.66	15.16	15.66	16.26	16.76	17.26	17.86	18.36	18.86	19.46	19.96	20.46	21.06	21.56	22.06	22.66	23.16	23.66	24.26	24.76

*Dco values are given in mL/min/mm Hg. The values listed here reflect the Dco as listed in Table 5-7a minus 5.74 (95% confidence interval). Adapted from Crapo and Morris.[9]

APPENDIX C

IMPAIRMENT CLASSIFICATION FOR RESPIRATORY DISEASE, USING PULMONARY FUNCTION AND EXERCISE TESTS

	TEST	FVC	FEV_1	FEV_1/FVC	Dco	VO_2 MAX	PERCENT VALUE OF WHOLE PERSON
GRADE	1	Measured FVC ≥ lower limit of normal AND	Measured FEV_1 ≥ lower limit of normal AND	FEV_1/FVC ≥ lower limit of normal AND	Dco ≥ lower limit of normal OR	VO_2 MAX ≥ 25 ml/(kg.min) OR > 7.1 METS	0
	2	≥ 60% of predicted and < lower limit of normal OR	≥ 60% of predicted and < lower limit of normal OR		≥ 60% of predicted and < lower limit of normal OR	≥ 20 and < 25 ml/(kg. min) OR 5.7 -7.1 METS	10 - 25
	3	≥ 51% and ≤ 59% of predicted OR	≥ 41% and ≤ 59% of predicted OR		≥ 41% and ≤ 59% of predicted OR	≥ 15 and <20 (ml/(kg.min) OR 4.3 to < 5.7 METS	26 - 50
	4	≤ 50% of predicted OR	≤ 40% of predicted OR		≤ 40% of predicted OR	< 15 ml/(Kg.min) OR < 1.05 L/min OR < 4.3 METS	51 - 100

EFFECTIVE DATE: July 4, 2025
AUTHORITY: Sections 195(1) and 195(3) of the *Act*
CROSS REFERENCES: Item C6-39.00, *Section 195 Permanent Partial Disability Benefits*, of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY: July 4, 2025 − Amendment to section III. (Upper Extremity) subsection E (Miscellaneous Conditions and Surgical Procedures) to remove biceps tendon rupture (with no surgical correction) fixed disability ratings and amendments to section XIII. (Traumatic Hearing Loss) to align with section XIV. (Non-Traumatic Hearing Loss), and to provide further guidance on presbycusis.
September 1, 2024 − Amendments to the loss of strength ratings in the following: section III. (Upper Extremity) subsection D (Loss of Strength); section VI. (Lower Extremity) subsection G (Loss of Strength); section VIII. (Peripheral Nervous System Conditions) subsection A (Motor Rating Criteria), subsection B (Table of Ratings for Peripheral Nervous System Conditions); section IX. (Neve Root Conditions) subsection A (Motor Rating Criteria), subsection B (Table of Ratings for Nerve Root Conditions).
June 17, 2024 − Housekeeping amendments to Section XII. Vision Disability to correct certain numerical values in the visual field values chart.
December 1, 2023 − Amendments to improve clarity and readability of the following: section IX (Nerve Root Conditions), subsection B (Table of Ratings for Nerve Root Conditions), section XI (Central Nervous System Conditions), subsection F (Stance and Gait) with corresponding consequential amendments to section VI (Lower Extremity), and section XI (Central Nervous System Conditions), subsection G (Impairments of the Upper Extremities).
May 15, 2023 − Non-Traumatic hearing loss section amended to reflect amendments to Schedule 2 of the *Act*.
March 1, 2023 − An amendment to section lll (Upper Extremity), subsection E (Miscellaneous Conditions and Surgical Procedures), to remove inaccurate terminology, and an amendment to section V (Hands), subsection D (Loss of Strength), to clarify evaluation methodology.
November 24, 2022 − Housekeeping changes to the non-traumatic hearing loss (Schedule 2/Section 145 of the *Act*) section consequential to implementing the *Workers Compensation Amendment Act (No. 2), 2022* (Bill 41).
February 1, 2022 − Revised current ratings for photophobia; and added criteria to the three categories of photophobia.
January 1, 2021 − Housekeeping changes made to cross-references consequential to reformatting and renumbering policies in Chapter 6, *Permanent Disability Benefits*.
September 1, 2020 − Policy amended to correct a cross-referencing error.
April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
December 1, 2019 − Set the rating for comminuted calcaneal fractures at 7%; clarified ratings for nerve root and peripheral nervous system conditions affecting part of the nerve's distribution; and made minor editorial changes.

January 1, 2019 – Updated Vision and Loss of Strength. Revised a typographical error in Vestibular Disorders.
May 1, 2017 – Added obturator nerve to section VIII. Peripheral Nervous System Conditions. Changed the percentages of disability for permanent tracheostomy, significant tracheal obstruction and minor tracheal obstruction; changed the range of motion rating threshold for the spine and limbs; and made minor consequential amendments including typographical errors and edits for clarification.
January 1, 2015 – consolidated and incorporated policy items #31.90, #39.11, #39.12, #39.13, #39.20, #39.21, #39.30, #39.31, #39.32, #39.40, #39.41, #39.42, #39.43, and #39.44 of the *Rehabilitation Services & Claims Manual,* Vol II., and portions of the *Additional Factors Outline*.
January 1, 2007 – policy changes to add item 81 Asthma and item 82 Contact Dermatitis to the Permanent Disability Evaluation Schedule.
August 1, 2003 – substantial changes to the Permanent Disability Evaluation Schedule including changes to the percentage(s) of disability for partial amputation of the digits, spine and pronation/supination. Housekeeping changes.
July 16, 2002 – housekeeping changes.

APPLICATION: Applies to all decisions made on or after July 4, 2025.

APPENDIX 4

FORMULAE FOR RECALCULATING PERMANENT DISABILITY BENEFITS UNDER SECTION 203 – ITEM C6-46.00

A. Calculation for Workers Under 65

(a) Deemed current permanent disability benefits (the monthly amount being paid on the date of adjustment, plus any periodic payments that have been commuted). See Supplement No. 8.

_____ a)

(b) Monthly wage at time of injury, limited by the maximum then in effect. _____ b)

(c) Average monthly wage for B.C. during the year of injury (see B.C. Monthly Average Wage Table, Supplement No. 1).

_____ c)

(d) Ratio of the monthly wage at time of injury to the B.C. average wage for that year, i.e. (b)/(c) _____ d) (4 decimals)

(e) Estimated average monthly wage for B.C in the year of the adjustment (B.C Average Wage Table, Supplement No. 1) _____ e)

(f) Projection of pre-injury wage, limited by any maximum to the date of adjustment, i.e. including adjustment on the basis of age at date of injury (Supplement No. 9), i.e. (d) x (e) x factor. _____ f)

(g) Projected monthly earnings, limited by maximum and earnings capacity (calculated according to Supplement No. 2). _____ g)

(h) Estimated difference in earnings at time of adjustment.

(i) single injury (f) – (g)

OR

(ii) multiple claims (calculated according to Supplement No. 3). _____ h) (if negative, enter zero)

(i) Adequate compensation = .75 x (h). _____ i)

(j) Potential adjustment to monthly amount, i.e., (i) – (a). _____ j) (if negative, enter zero)

(k) Statutory maximum (maximum earnings applicable under section 209 on the date of adjustment). _____ k)

(l) Maximum which would be currently payable to a worker in the pre-injury occupation of the applicant worker with a permanent disability assessed at 100%, i.e., .75 x (k). _____ l)

(m) Percentage of total disability that would be rated at the date of the adjustment to a worker with the same disability as the applicant worker. _____ m)

(n) Maximum adjusted amount applicable on this claim (l) x (m). _____ n)

(o) Adjusted monthly amount = lesser of (n) or (i). _____ o)

(p) Actual adjustment. Permanent disability benefits increased by (o) – (a).

The new periodic payment for the permanent disability benefit is the amount shown in (o). _____ p)

B. Calculation for Workers 65 and Over

(a) Year of Birth. _____ a)

(b) Year of Injury. _____ b)

(c) Deemed current permanent disability benefit amount (the monthly amount being paid on the date of the adjustment, plus any periodic payments that have been commuted). See Supplement No. 8.

_____ c)

(d) Projected monthly loss of retirement income from reduced savings (calculated according to Supplement No. 4.).

_____ d)

(e) Monthly reduction of post-retirement earning capacity (calculated according to Supplement No. 5). _____ e)

(f) Projected monthly income loss from other retirement sources (calculated according to Supplement No. 6). _____ f)

(g) Projected retirement income loss (d + e + f). _____ g)

(h) Adequate compensation, i.e., .75 x (g)

_____ h)

(i) Potential adjustment to monthly amount, i.e., (h) – (c). _____ i)
(if negative, enter zero)

(j) Statutory maximum (maximum earnings applicable under section 209 on the date of adjustment). _____ j)

(k) Maximum which would be currently payable to a worker in the pre-injury occupation of the applicant worker with a permanent disability assessed at 100%, i.e., .75 x (j). _____ k)

(l) Percentage of total disability that would be rated at the date of the adjustment to a worker with the same disability as the applicant worker.

_____ l)

(m) Maximum adjusted amount applicable on the claim, i.e., (l) x (k). _____ m)

(n) Adjusted monthly amount, i.e., lesser of (m) or (h). _____ n)

(o) Actual adjustment, permanent disability benefits increased by (n) – (c). _____ o)

SUPPLEMENT NO. 1

B.C. MONTHLY AVERAGE WAGE[1] TABLE

Calendar Year	Index
1997	$2,659.00
1998	2,679.00
1999	2,705.00
2000	2,755.00

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

[1] Computed as 4.33 times the Industrial Aggregate Average Weekly Wage for British Columbia. Editions of this table distributed prior to 1986 were based on the Industrial Composite Average Weekly Wage for British Columbia. The basis for the Industrial Aggregate was changed in 1994. The average wage index for each of the years in this table has been put on the current Industrial Aggregate basis, so that ratios can be taken between indexes for any two years in the table.

SUPPLEMENT NO. 2

PROJECTED MONTHLY EARNING CAPACITY, NOT LIMITED BY MAXIMUM

(1) Actual monthly earnings from work and income from self-employment. _____ 1)

(2) Adjustment to present monthly earnings to allow for transitory circumstances and arrive at a long-term projection. _____ 2)

(3) Projected monthly earnings = 1) adjusted by 2). _____ 3)

(4) Any earnings reduction resulting from personal choice or circumstance unrelated to the compensable disability, e.g. a non-compensable disability, personal preference for an occupation less well paid than one that the worker could reasonably undertake or voluntary retirement. _____ 4)

(5) Projected monthly earnings adjusted for non-compensable loss, (3) + (4). _____ 5)

The figure in Item (5) is transferred to Item (g) on the worksheet for workers under 65.

SUPPLEMENT NO. 3

ESTIMATE OF DIFFERENCE IN EARNINGS AT TIME OF ADJUSTMENT TO EACH CLAIM IN A MULTIPLE CLAIM SITUATION

(1) Actual present monthly earnings from employment and self-employment.

under 65, calculation sheet Item (g)

OR

aged 65 or over, Supplement 4 Item (8). _____ 1)

(2) Highest projected monthly earnings of all the claims being considered.

under 65, calculation sheet Item (f)

OR

aged 65 or over, Supplement 4 Item (7). _____ 2)

(3) Earnings impairment at time of adjustment based on claim with highest projected wage, i.e. (2) – (1). _____ 3) (if negative, enter zero)

(4) Sum of disability percentages from all claims in the multiple series. _____ 4)

(5) Percentage of disability for this claim, Claim No. ___ of ___ Multiple Claims. _____ 5)

(6) Estimate of monthly earnings loss as if this claim had been the only disability sustained, i.e. (5)/(4) x (3) _____ 6)

ITEM (6) IS TRANSFERRED TO (h) IN THE CALCULATION SHEET FOR WORKERS UNDER 65, OR TO SUPPLEMENT 4 ITEM 9, WHEN CONSIDERING WORKER AGED 65 OR OVER.

Note, if Item 3 on this supplement is zero for the first claim considered, it will be zero for all claims in the series.

SUPPLEMENT NO. 4

PROJECTED MONTHLY LOSS OF RETIREMENT INCOME FROM REDUCED SAVINGS

(1) Year in which age 65 was attained. _____ 1)

(2) Disabled work years due to compensable disability, i.e., (1) – year of injury. _____ 2)

(3) Monthly wage at time of injury, limited by the maximum then in effect. _____ 3)

(4) Average monthly wage for B.C. during the year of injury (see B.C. Monthly Average Wage Table, Supplement No. 1). _____ 4)

(5) Ratio of the monthly wage at time of injury to the B.C. average wage for that year, i.e., (3)/(4). _____ 5)
(4 decimals)

(6) Estimated average monthly wage for B.C. in the year worker attained age 65 (see B.C. Monthly Average Wage Table, Supplement No. 1). _____ 6)

(7) Projection of pre-injury wage, limited by any maximum, to the year in which age 65 was attained, including adjustment on the basis of age at date of injury, (Supplement No. 9), i.e., (5) x (6) x factor. _____ 7)

(8) Adjusted monthly earnings in year age 65 was attained, limited by a maximum (calculated according to Supplement No. 7). _____ 8)

(9) Estimated difference in earnings in year age 65 was attained:

(i) single injury, i.e. (7) – (8)

OR

(ii) multiple claims (calculated according to Supplement No. 3). _____ 9)
(if negative, enter zero)

(10) Ratio of the estimated difference in earnings to the B.C. average wage in the year age 65 was attained, i.e. (9)/(6). _____10) (4 decimals)

(11) Estimated average monthly wage for B.C. in the year of adjustment (see Supplement No. 1). _____11)

(12) Projection of estimated monthly wage-loss in the year age 65 was attained to the date of adjustment, i.e., (10) x (11). _____12)

(13) Total work months disabled due to compensable disability, i.e., 12 months/year x (2). _____13)

(14) Lifetime lost earnings to age 65 expressed in terms of most recent dollars, i.e., (12) x (13). _____14)

(15) Deemed total permanent disability benefit payments to age 65 = deemed current permanent disability benefit (including term pensions expiring at age 65) x (13). _____15)

(16) Net lifetime lost income, i.e., (14) – (15). _____16)

(17) Projected monthly loss of retirement income from reduced savings, i.e., 0.0005 x (16). _____17)

THE FIGURE SHOWN AS ITEM (17) IS TRANSFERRED TO ITEM (d) ON THE CALCULATION SHEET FOR WORKERS 65 AND OVER.

SUPPLEMENT NO. 5

MONTHLY REDUCTION OF POST-RETIREMENT EARNING CAPACITY

(1) Percentage of total disability that would be rated at the date of the adjustment for the worker's permanent disability. %_____1)

(2) Monthly compensation for loss of earning capacity from the disability.
$0.80 for each 1% of total disability, i.e.,
$0.80/per 1% x (1). $_____ 2)

THIS FIGURE SHOWN AS ITEM (2) IS TRANSFERRED TO ITEM (e) ON THE CALCULATION SHEET FOR WORKERS AGED 65 AND OVER.

The cash figure in Item (2) will be adjusted with the Consumer Price Index, the first such adjustment being made on July 1, 1976.

Since June 30, 2002, the percentage change in the Consumer Price Index determined under section 333 of the *Act*, as described in Item C7-51.00, is used.

Rates

January 1, 2025	–	$4.41 for each 1%
January 1, 2026	–	$4.51 for each 1%

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

SUPPLEMENT NO. 6

PROJECTED MONTHLY LOSS OF OTHER RETIREMENT INCOME

ACTUAL INCOME PER MONTH (apart from earnings)

(1) Canada Pension benefits. _____ 1)

(2) Pension benefits from employment (employer-operated or occupational pension plan). _____ 2)

(3) Other government benefits (but not Mincome or similar guarantees). _____ 3)

(4) Total actual retirement income; total of (1) through (3). _____ 4)

PROJECTED INCOME BENEFIT PER MONTH (estimated retirement income the worker would be receiving if the compensable injury had not occurred. The projected benefits are based on the assumption that if the disability had not occurred, the worker would have remained in the pre-injury occupation until the age of 65 years).

(5) Canada Pension Plan benefits. _____ 5)

(6) Pension benefits from employment (employer-operated or occupational pension plan). _____ 6)

(7) Other government benefits (but not Mincome or similar guarantees). _____ 7)

(8) Total projected retirement income, i.e., total of Items (5) through (7). _____ 8)

(9) Retirement income loss (8) – (4). _____ 9)

THE FIGURE FOR ITEM (9) IS TRANSFERRED TO ITEM (f) ON THE WORKSHEET OF SECTION B “CALCULATION FOR WORKERS 65 AND OVER”.

SUPPLEMENT NO. 7

ADJUSTED MONTHLY INCOME FROM EMPLOYMENT, SELF-EMPLOYMENT AND REPLACEMENT EARNINGS SOURCES IMMEDIATELY PRIOR TO AGE 65

(1) Monthly earnings immediately prior to age 65. _____ 1)

(2) Adjustment for any loss of earnings resulting from personal circumstances unrelated to the disability, i.e., a non-compensable disability that arose subsequent to the disability, or personal preference for early retirement. _____ 2)

(3) Estimated equivalent monthly income worker was receiving from a source which in nature replaced earnings income because of a non-compensable disability. _____ 3)

(4) Adjusted monthly income, i.e., (1) + (2) + (3). _____ 4)

THE FIGURE SHOWN AS ITEM (4) IS TRANSFERRED TO (8) ON SUPPLEMENT NO. 4.

SUPPLEMENT NO. 8

CALCULATION OF DEEMED CURRENT PERMANENT DISABILITY BENEFITS

(1) Monthly payment for either permanent partial or permanent total disability which is currently being paid to the worker. _____ 1)

(2) Value of commutation(s) in terms of $ per month as at date of commutation. _____ 2)

(3) Deemed current permanent disability benefits (1) + (2). _____ 3)

ITEM (3) IS TRANSFERRED TO ITEM (c) ON THE CALCULATION SHEET FOR WORKERS 65 AND OVER OR TO ITEM (a) ON THE CALCULATION SHEET FOR WORKERS UNDER 65.

SUPPLEMENT NO. 9

ADJUSTMENT OF PRE-INJURY WAGE ON THE BASIS OF AGE AT DATE OF INJURY

Age at Date of Injury	Adjustment Factor
14	2.0
15	1.7
16	1.5
17	1.3
18	1.2
19	1.2
20	1.1
21	1.1
22	1.1
23 or over	1.0

APPENDIX 5

MAXIMUM FINES FOR COMMITTING OFFENCES UNDER THE COMPENSATION PROVISIONS OF THE *ACT*

Section 236(1) provides that "A person who commits an offence under a compensation provision for which no other punishment has been provided is liable on conviction to a fine not greater than. . ." the amount set out below.

Date			Amount
January 1, 2025	–	December 31, 2025	$6,689.64
January 1, 2026	–	December 31, 2026	$6,834.35

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