REHABILITATION SERVICES & CLAIMS MANUAL

VOLUME II

Published by the
Workers' Compensation Board
Province of British Columbia

Workers and Workplaces
Safe and Secure from Injury and Disease

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PREFACE

Section 82 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 compensation, assessment, rehabilitation and occupational safety and health (or prevention).

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 headings "Background" and "Practice" and 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*.

EXPLANATION OF HOW TO USE VOLUME II OF THIS *MANUAL*

Volume II comprises:

1. A Preface;
2. A Table of Contents;
3. Eighteen chapters;
4. Seven appendices.

The Table of Contents is a list of the numbered headings and sub-headings found in each chapter and states the page where the heading or sub-heading may be found. A search of the Table of Contents will help you to discover which parts of the manual deal with any particular issue with which you are concerned.

The material in the chapters is arranged logically according to subject matter and not in the same order as matters are dealt with in the *Workers Compensation Act*. As it deals with different subjects, the manual sets out the relevant provisions of the *Act* but does not set out the whole of the *Act* in one place. Each chapter is divided into headings and sub-headings according to subject matter. These headings and sub-headings are numbered consecutively for ease of reference.

The bracketed numbers found throughout the text of the chapters refer to the Notes at the end of each chapter. Cross-references to other parts of the manual are simply given by heading or sub-heading number.

References to sections of the *Workers Compensation Act* in the Notes use an "S." abbreviation for "section" and do not specifically refer to that *Act*. For instance, "s.2" means section 2 of the current *Workers Compensation Act*. A reference to a section of any other statute will specifically name that statute.

The appendices contain various schedules and fines with cross-references to the main text.

The numbering of pages recommences at 1 at the beginning of each chapter and appendix. The pages in different chapters are distinguished by placing the number of the chapter and a hyphen before the page number. For example, page 3-2 is page 2 of Chapter 3. The pages in each appendix are distinguished by placing A plus the number of the appendix and a hyphen before the page number. For instance, page A2-3 is page 3 of Appendix 2.

Replacement pages for Volume II will be issued from time to time.

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CHAPTER 1

SCOPE OF VOLUME II OF THIS *MANUAL*

#1.00 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.

#1.01 Legislative Amendments

(a) *Workers Compensation Amendment Act, 2002* (“*Amendment Act, 2002”)*

The *Amendment Act, 2002* is also referred to as “Bill 49”. It primarily amended the *Workers Compensation Act:*

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

(b) *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 *Workers Compensation 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.

(c) *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 *Workers Compensation Act*:

- effective June 30, 2002 in relation to benefits 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.

#1.02 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 benefits 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 benefits for an injured worker are to be determined under Volume 1 or Volume II depends upon the transitional rules set out in policy item #1.03 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 benefits 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 includes 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.

#1.03 Scope of Volumes I and II in Relation to Benefits for Injured Workers

(a) General

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The following are examples of a recurrence:

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

- A worker is in receipt of a permanent partial disability award and the disability subsequently worsens so that the worker is

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

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

EFFECTIVE DATE: August 1, 2006

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

HISTORY: December 31, 2003 – Amendments to reflect consequential changes to the *Act* resulting from the *Amendment Act*, 2003.
June 17, 2003 – Reorganization of format and addition of content to address the scope of Volumes I and II of the Manual.
October, 16, 2002 – Amendments to clarify meaning of "recurrence" for the purposes of section 35.1(8) of the *Act*.

#1.10 The Persons Covered by the *Act*

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

#1.20 The Conditions under which Compensation is Payable

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

#1.30 The Type and Amount of Compensation

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

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

#1.40 Charging of Claims Costs

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

#2.00 WORKERS' COMPENSATION BOARD

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

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

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

APPLICATION: Not applicable.

#2.10 Jurisdiction over Claims Adjudication

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

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

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

APPLICATION: Not applicable.

#2.20 Application Of The *Act* And Policies

In making decisions, 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 applying the relevant provisions of the *Act* and the relevant policies, 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 99(2) of the Act provides that:

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

In making decisions, the Board must take into account all relevant facts and circumstances relating to the case before them. This is required, among other reasons, in order to comply with section 99(2) of the *Act*. In doing so, 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.

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

All substantive and associated practice components in the policies in this Manual are applicable under section 99(2) of the *Act* and must be followed in decision-making. The term "associated practice components" for this purpose refers to the steps outlined in the policies that must be taken to determine the substance of decisions. Without these steps being taken, the substantive decision required by the Act and policies could not be made.

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

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

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

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officers.
HISTORY:	March 3, 2003 – Amendments 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.
APPLICATION:	Applies on or after June 1, 2009

NOTES

(1)	Chapter 2	
(2)	Chapter 8	
(3)	Chapter 3	
(4)	Chapter 4	
(5)	Chapters 3 and 4	
(6)	Chapter 3	
(7)	Chapter 5	
(8)	Chapter 6	
(9)	Chapter 8	
(10)	Chapter 10	
(11)	Chapter 11	
(12)	Chapter 17	
(13)	S.1 S.80	
(14)	S.1	
~~(15)~~	~~S.81~~	**DELETED**
~~(16)~~	~~S.82~~	**DELETED**
(17)	S.96(1)	
~~(18)~~	~~Chapter 12~~	**DELETED**
~~(19)~~	~~Chapter 13~~	**DELETED**

CHAPTER 2

WORKERS AND EMPLOYERS COVERED BY THE *ACT*

#3.00 INTRODUCTION

Section 2(1) of the *Act* states as follows:

> "This Part applies to all employers, as employers, and all workers in British Columbia except employers or workers exempted by order of the board."

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

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 this province is given the same rights to compensation as workers under the provincial *Act*. The persons considered "employees" are dealt with in this chapter.

#4.00 EXEMPTIONS AND EXCLUSIONS FROM COVERAGE

The criteria for the exemption of employers or workers may be found in policy in Item AP1-2-1 of the *Assessment Manual* along with general exemptions which are described in detail. The policy in Item AP1-2-1 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 B.C. industry.

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

APPLICATION: Not applicable.

#5.00 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 his 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 AP1-1-4 of the *Assessment Manual*.

EFFECTIVE DATE: March 18, 2003 (as to numerical reference to the policy in Item AP1-1-4 in the *Assessment Manual*)

APPLICATION: Not applicable.

#6.00 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, written or oral, express or implied, a person engaged in work in or about an industry;
>
> 'Worker' includes
>
> (a) a person who has entered into or works under a contract of service or apprenticeship, written or oral, express or implied, whether by way of manual labour or otherwise;

Detailed discussions concerning the definitions of worker and employer may be found in the policies in Items AP1-1-1, AP1-1-4 and AP1-1-5 of the *Assessment Manual*.

EFFECTIVE DATE: March 18, 2003 (as to numerical references to the policies in Items AP1-1-1, AP1-1-4 and AP1-1-5 in the *Assessment Manual*)

APPLICATION: Not applicable.

#6.10 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 three types of relationship. The persons doing the work may be independent firms, labour contractors, or workers.

Very detailed registration rules concerning independent firms, labour contractors, and workers are outlined in the policies in Items AP1-1-2, AP1-1-3, AP1-1-5 and AP1-1-7 of the *Assessment Manual*.

EFFECTIVE DATE: March 18, 2003 (as to numerical references to the policies in Items AP1-1-2, AP1-1-3, AP1-1-5 and AP1-1-7 in the *Assessment Manual*)

APPLICATION: Not applicable.

#6.20 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 AP1-1-5 and AP1-3-1 of the *Assessment Manual*.

EFFECTIVE DATE: March 18, 2003 (as to numerical references to the policies in Items AP1-1-5 and AP1-3-1 in the *Assessment Manual*)

APPLICATION: Not applicable.

#7.00 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, AP1-1-3, AP1-1-5, AP1-1-7 and AP1-97-1 of the *Assessment Manual*.

EFFECTIVE DATE: March 18, 2003 (as to numerical references to the policies in Items AP1-1-1, AP1-1-3, AP1-1-5, AP1-1-7 and AP1-97-1 in the *Assessment Manual*)

APPLICATION: Not applicable.

#7.10 Coverage for Volunteer Firefighters

Individuals volunteering as a firefighter for a municipality or other form of local government are given coverage by the definition of “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 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 or death which occurs while routinely commuting to and from the fire department.

A volunteer firefighter's travel may be considered part of his or her 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 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 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 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 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

CROSS-REFERENCE: Policy items #14.00, *Arising Out of and in the Course of Employment;* #18.00, *Travelling To and From Work;* #20.00, *Extra-Employment Activities;* #20.20, *Recreational, Exercise or Sports Activities;* #20.30, *Education or Training Courses* and #20.50, *Fund Raising, Charitable or Other Similar Activities*

APPLICATION: Applies to all injuries on or after October 1, 2007.

#8.00 ADMISSION OF WORKERS, EMPLOYERS, AND INDEPENDENT OPERATORS

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

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

EFFECTIVE DATE: March 18, 2003 (as to numerical references to the policies in Items AP1-1-6, AP1-2-2, AP1-2-3 and AP1-3-1 in the *Assessment Manual*)

APPLICATION: Not applicable.

#8.10 Federal Government Employees

The *Government Employees Compensation Act* 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 this *Act* 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, company, corporation, commission, board or agency established to perform a function or duty on behalf of the Government of Canada 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, company, corporation, commission, board or agency established to perform a function or duty on behalf of the Government of Canada, is taking a training course that is approved by the Minister for that person,

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

(e) any officer or employee of the Senate, the House of Commons or the Library of Parliament".

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 *Government Employees Compensation Act*. 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 *Government Employees Compensation Act*.

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 5(1):

> Where, in an industry within the scope of this Part, personal injury or death arising out of and in the course of the employment is caused to a worker, compensation as provided by 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 the employment is caused to a 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 5(1) rather than under section 21(8);
- psychological impairment. Conditions of this type may be a compensable consequence of an accepted personal injury or occupational disease (see

Item C3-22.30, *Compensable Consequences – Psychological Impairment*); 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 policy item #26.55, *Aggravation of a Disease*).

Apart from personal injury, the Board is authorized:

(1) by section 5.1, 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 Item C3-13.00, *Section 5.1 – Mental Disorders);*

(2) by section 6, to compensate a worker for an occupational disease, (see Chapter 4, *Compensation for Occupational Disease*); and

(3) by section 21(8), to replace or repair workers' artificial appliances, eyeglasses, dentures and hearing aids damaged or broken at work. (See Item C3-23.00, *Replacement and Repair of Personal Possessions – Section 21(8)*).

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. To be compensable as an injury, however, 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 is suffering from 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.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(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 21(8);* Chapter 4, *Compensation for Occupational Disease;* Policy item #26.03, *Recognition by Regulation of General Application;* Schedule B of the *Act.*
HISTORY:	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:	This item applies to all claims for injuries occurring on or after July 1, 2010.

RE: 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 5(1):

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

Section 97:

> 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 the Province.

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:

(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*, R.S.C. 1985, c. G-5 ("*GECA*").

The employees covered by the *GECA* are also discussed in policy item #8.10, *Federal Government Employees*.

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 B.C. under section 4(1) of the *GECA* is, in effect, the same as the test for entitlement for other workers in B.C. under section 5(1) of the B.C. *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 B.C. where he or she is appointed or engaged to work in B.C. In accordance with the *GECA*, federal government employees considered to be "usually employed" somewhere other than in B.C. will not be covered by the B.C. *Act*.

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

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(1) of the *Act.*
CROSS REFERENCES:	Policy item #8.10, *Federal Government Employees*.
HISTORY:	The interpretation that the test for entitlement under section 4(1) of the *GECA* is equivalent to the test for entitlement under section 5(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 the employment.

2. The Act

Section 5(1):

> Where, in an industry within the scope of this Part, personal injury or death arising out of and in the course of the employment is caused to a worker, compensation as provided by 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.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(1) of the *Act.*
CROSS REFERENCES:	Item C3-19.00, *Work-Related Travel* (B. Journeys to a Remote Worksite).
HISTORY:	This policy replaces 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 5(1):

> Where, in an industry within the scope of this Part, personal injury or death arising out of and in the course of the employment is caused to a worker, compensation as provided by 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 a permanent disability award.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	October 1, 2007
AUTHORITY:	Section 5(1) of the *Act*.
CROSS REFERENCES:	Item C3-16.10, *Pre-Existing Conditions – Specific Injuries;* Item C3-22.00, *Compensable Consequences*; Policy item #25.10, *Legislative Requirements*; Policy item #35.30, *Duration of Temporary Disability Benefits*; Item C11-88.80, *Vocational Rehabilitation – Preventive Rehabilitation.*
HISTORY:	This policy replaces 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: Section 5.1 – Mental Disorders	ITEM: C3-13.00

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 5.1 of the *Act*.

2. The Act

Section 5.1:

(1) Subject to subsection (2), a worker is entitled to compensation for a mental disorder that does not result from an injury for which the worker is otherwise entitled to compensation, only if the mental disorder

(a) either

(i) is a reaction to one or more traumatic events arising out of and in the course of the worker's employment, or

(ii) is 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) is diagnosed by a psychiatrist or psychologist as a mental or physical condition that is described in the most recent American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders at the time of the diagnosis, and

(c) 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.

(2) 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.

(3) Section 56(1) applies to a psychiatrist or psychologist who makes a diagnosis referred to in this section.

(4) 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*;

"firefighter" means a member of a fire brigade who is

(a) described in paragraph (c) of the definition of "worker" or employed by the government of Canada, and

(b) assigned primarily to fire suppression duties whether or not those duties include the performance of ambulance or rescue services;

"police officer" means an officer as defined in section 1 of the *Police Act*;

"psychiatrist" means a physician who is recognized by the College of Physicians and Surgeons of British Columbia, or another accredited body recognized by the Board, as being a specialist in psychiatry;

"psychologist" means a person who is

(a) a registrant of the college responsible for carrying out the objects of the *Health Professions Act* in respect of the health profession of psychology, or

(b) entitled to practise as a psychologist under the laws of another province.

"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.

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 in the most recent American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* ("DSM"). 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 either:

- is a reaction to one or more traumatic events arising out of and in the course of the worker's employment; or
- is 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 5.1 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 5(1) for psychological impairment that is a compensable consequence of an injury.

A. Does the worker have a DSM diagnosed mental disorder?

Section 5.1 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 5.1(2) 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 the worker's employment.

The Board recognizes that workers may, due to the nature of their work, be exposed to traumatic events or significant stressors as part of their employment. An event may be traumatic or a stressor significant even though the worker has previous work-related exposure to traumatic events or significant stressors.

In determining whether the event is traumatic or the stressor is significant, the worker's subjective statements and response to the event or stressor are considered. However, this question is not determined solely by the worker's subjective belief about the event or stressor. It involves both a subjective and objective analysis.

For the purposes of this policy, 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 a worker's employment.

Interpersonal conflicts between the worker and his or her supervisors, co-workers or customers are not generally considered significant unless the conflict results in behavior that is considered threatening or abusive.

Examples of significant work-related stressors include exposure to workplace bullying or harassment.

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 there is sufficient evidence of one or more traumatic events that are of causative significance in the mental disorder.

The gathering and weighing of evidence generally is covered in policy items #97.00 through #97.60.

(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 5.1 of the *Act* and the direction in this policy.

E. Section 5.1(1)(c) Exclusions

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. The *Act* provides a list of examples of decisions 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 may include decisions of the employer relating to workload and deadlines, work evaluation, performance management, transfers, changes in job duties, lay-offs, demotions and reorganizations.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 23, 2018
AUTHORITY:	Section 5.1 of the *Act.*
CROSS REFERENCES:	Item C3-13.10, *Section 5.1(1.1) – Mental Disorder Presumption*; Item C3-22.30, *Compensable Consequences – Psychological Impairment*; Policy item #97.00, *Evidence*; Policy item #97.10, *Evidence Evenly Weighted*; Policy item #97.20, *Presumptions*; Policy item #97.30, *Medical Evidence*; Policy item #97.31, *Matter Requiring Medical Expertise*; Policy item #97.32, *Statement of Worker about His or Her Own Condition*; Policy item #97.33, *Statement by Lay Witness on Medical Question*; Policy item #97.34, *Conflict of Medical Opinion*; Policy item #97.35, *Termination of Benefits*; Policy item #97.40, *Disability Awards*; Policy item #97.50, *Rumours and Hearsay*; Policy item #97.60, *Lies*.
HISTORY:	Amendments to C3-13.00 to reflect changes to the *Act* resulting from the *Workers Compensation Amendment Act, 2018*. Housekeeping changes made on January 1, 2018 to the definition of “psychologist” as amended by the *Act* effective November 2, 2017. Housekeeping changes made on July 17, 2013 to remove references to multi-axial diagnostic assessment in accordance with DSM-5. New Item C3-13.00 to reflect changes to the *Act* resulting from the *Workers Compensation Amendment Act, 2011.* This policy replaces former Item C3-13.00 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. Effective 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*. On 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 section 5.1, if their claims had initially been allowed prior to June 30, 2002.

On December 31, 2003, former policy item #13.30 was amended to reflect the amendment of section 5.1(1) of the *Act*, to include a reference to a psychologist's diagnosis of mental stress, and the introduction of sections 5.1(2) to (4) of the *Act*. The amended policy applied to acute reactions to traumatic events that occur 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: This Item applies to all decisions made by the Board and the Workers' Compensation Appeal Tribunal respecting claims that involve section 5.1 of the *Act* made on or after July 23, 2018, including all decisions made, but not finally adjudicated, before July 23, 2018.

RE:	Section 5.1(1.1) – Mental Disorder Presumption	ITEM:	C3-13.10

BACKGROUND

1. Explanatory Notes

This policy provides guidance on the adjudication of claims for a mental disorder where the presumption in section 5.1(1.1) of the *Act* applies.

2. The Act

Section 5.1:

(1) Subject to subsection (2), a worker is entitled to compensation for a mental disorder that does not result from an injury for which the worker is otherwise entitled to compensation, only if the mental disorder

…

(b) is diagnosed by a psychiatrist or psychologist as a mental or physical condition that is described in the most recent American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders at the time of the diagnosis, and

…

(1.1) 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 is recognized, in the most recent American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, at the time of the diagnosis of the mental disorder under subsection (1)(b) of this section, 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.

(2) 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.

(3) Section 56(1) applies to a psychiatrist or psychologist who makes a diagnosis referred to in this section.

(4) 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*;

“firefighter” means a member of a fire brigade who is

(a) described in paragraph (c) of the definition of "worker" or employed by the government of Canada, and

(b) assigned primarily to fire suppression duties whether or not those duties include the performance of ambulance or rescue services;

“police officer” means an officer as defined in section 1 of the *Police Act*;

“psychiatrist” means a physician who is recognized by the College of Physicians and Surgeons of British Columbia, or another accredited body recognized by the Board, as being a specialist in psychiatry;

“psychologist” means a person who is

(a) a registrant of the college responsible for carrying out the objects of the *Health Professions Act* in respect of the health profession of psychology, or

(b) entitled to practise as a psychologist under the laws of another province;

“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.

POLICY

Section 5.1(1.1) 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 American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders ("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 5.1(1) 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. Eligible occupations are correctional officers, emergency medical assistants, firefighters, police officers and sheriffs.

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.

C. DSM diagnosis

The *Act* requires a worker's mental disorder be diagnosed by a psychiatrist or a psychologist as a condition described in the most recent DSM, at the time of diagnosis. The *Act* also requires the mental disorder be recognized in the most recent DSM 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 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.

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 5.1(1.1) 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. 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. It is not sufficient to say the presumption is rebutted because there is a lack of evidence to support work causation.

The gathering and weighing of evidence generally is covered in policy items #97.00 through #97.60.

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 5.1(1.1) 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.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 23, 2018
AUTHORITY:	Section 5.1 of the *Act.*
CROSS REFERENCES:	Item C3-13.00, *Section 5.1 – Mental Disorders*; Item C3-22.30, *Compensable Consequences – Psychological Impairment*; Policy item #97.00, *Evidence*; Policy item #97.10, *Evidence Evenly Weighted*; Policy item #97.20, *Presumptions*; Policy item #97.30, *Medical Evidence*; Policy item #97.31, *Matter Requiring Medical Expertise*; Policy item #97.32, *Statement of Worker about His or Her Own Condition*; Policy item #97.33, *Statement by Lay Witness on Medical Question*; Policy item #97.34, *Conflict of Medical Opinion*; Policy item #97.35, *Termination of Benefits*; Policy item #97.40, *Disability Awards*; Policy item #97.50, *Rumours and Hearsay*; Policy item #97.60, *Lies*.
HISTORY:	New Item C3-13.10, *Section 5.1(1.1) – Mental Disorder Presumption,* to reflect changes to the *Act* resulting from the *Workers Compensation Amendment Act, 2018.*
APPLICATION:	This Item applies to all decisions made by the Board and the Workers' Compensation Appeal Tribunal respecting claims that involve section 5.1 of the *Act* made on or after July 23, 2018, including all decisions made, but not finally adjudicated, before July 23, 2018.

RE:	Arising Out of and In the Course of the 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 5(1):

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

Section 99(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 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 the Employment"

"Arising out of the 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 the Employment"

"In the course of the 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 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 employment.

The standard of proof is the balance of probabilities, and consideration is given to section 99(3) of the *Act*.

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 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 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 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, *Work-Related Travel*); and
- employer-provided facilities (see Item C3-20.00, *Employer-Provided Facilities*).

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 the 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, *Deviations from Employment*).

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.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(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.*
HISTORY:	This policy includes content from former policy items #14.00 and #21.30 of the *Rehabilitation Services & Claims Manual*, Volume II. Former policy item #14.00 was amended effective June 1, 2004 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:	This item applies to all 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 5:

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

. . .

(3) Where the injury is attributable solely to the serious and wilful misconduct of the worker, compensation is not payable unless the injury results in death or serious or permanent disablement.

POLICY

Before section 5(3) can be considered, it must first be determined under section 5(1) that the worker's personal injury or death arose out of and in the course of the employment. Item C3-14.00, *Arising Out of and In the Course of the Employment*, 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 employment under section 5(1). If such a conclusion is reached, the claim is disallowed, and section 5(3) 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 employment and there is an indication that misconduct of the worker played a role in the worker's injury or death, section 5(3) 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 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 employment.

If a worker's injury that was attributable solely to the worker's serious and wilful misconduct did result in death or serious or permanent disablement, it is compensable, and the employer may be eligible to have some of the costs of the temporary disability benefits excluded from its experience rating.

D. Employer's Experience Rating

Where temporary disability benefits were paid between January 1, 1994 and September 27, 2002 on a claim where the injury is attributable solely to the serious and wilful misconduct of the worker, but resulted in death or serious or permanent disablement, the cost of compensation paid after the first 13 weeks of temporary disability benefits is excluded from the employer's experience rating.

Where temporary disability benefits are paid on or after September 28, 2002 on a claim where the injury is attributable solely to the serious and wilful misconduct of the worker, but resulted in death or serious or permanent disablement, the cost of compensation paid after the first 10 weeks of temporary disability benefits is excluded from the employer's experience rating.

If temporary disability benefits were not paid because the claim that was attributable solely to the serious and wilful misconduct of the worker resulted in immediate death, no costs are excluded from the employer's experience rating.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(3) of the *Act.*
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of the Employment;* Item C3-17.00, *Deviations from Employment;* Policy item #115.30, *Experience Rating Cost Exclusions.*
HISTORY:	This policy replaces former policy item #16.60, *Serious and Wilful Misconduct*, of the *Rehabilitation Services & Claims Manual*, Volume II. The number of weeks of temporary disability 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 claims for injuries occurring on or after July 1, 2010.

RE: Accident – Section 5(4) 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:

> "accident" includes a wilful and intentional act, not being the act of the worker, and also includes a fortuitous event occasioned by a physical or natural cause;

Section 5(4):

> In cases where the injury is caused by accident, where the accident arose out of the employment, unless the contrary is shown, it must be presumed that it occurred in the course of the employment; and where the accident occurred in the course of the employment, unless the contrary is shown, it must be presumed that it arose out of the 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 5(4) 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 employment, unless the contrary is shown, it is presumed that the accident occurred in the course of the employment.

- Where an injury is caused by an accident that occurred in the course of the employment, unless the contrary is shown, it is presumed that the accident arose out of the 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 5(4) applies. For injuries resulting from an accident, evidence is only needed to establish either that the injury arose out of the employment or that it arose in the course of the employment. The other component of the test is presumed, unless there is evidence to the contrary.

This is not a conclusive presumption; it is rebutted if opposing evidence shows that the contrary conclusion is the more likely. Every reasonable effort is made to obtain all available evidence.

Where there is no "accident", the presumption in section 5(4) 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 5(4) of the *Workers Compensation Act*.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(4) of the *Act.*
CROSS REFERENCES:	Item C3-12.10, *Federal Government Employees.*
HISTORY:	This policy replaces former policy item #14.10 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: 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:

> "accident" includes a wilful and intentional act, not being the act of the worker, and also includes a fortuitous event occasioned by a physical or natural cause;

Section 5:

> (1) Where, in an industry within the scope of this Part, personal injury or death arising out of and in the course of the employment is caused to a worker, compensation as provided by this Part must be paid by the Board out of the accident fund.
>
> . . .
>
> (3) Where the injury is attributable solely to the serious and wilful misconduct of the worker, compensation is not payable unless the injury results in death or serious or permanent disablement.
>
> (4) In cases where the injury is caused by accident, where the accident arose out of the employment, unless the contrary is shown, it must be presumed that it occurred in the course of the employment; and where the accident occurred in the course of the employment, unless the contrary is shown, it must be presumed that it arose out of the 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 the 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 5(4) 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 5(3) of the *Act*.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(1) to 5(4) of the *Act.*
CROSS REFERENCES:	Item C3-14.10, *Serious and Wilful Misconduct;* Item C3-14.20, *Accident – Section 5(4) Presumption;* Item C3-17.00, *Deviations from Employment;* Item C3-18.10, *Clothing and Footwear.*
HISTORY:	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 5(1):

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

Section 99(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, *Arising Out of and In the Course of the Employment*, is the principal policy for determining whether a worker's injury arises out of and in the course of the 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 employment, and the adjudication rests on whether the injury also arose out of the 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 his or her 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 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 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 there is insufficient evidence 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 sufficient.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(1) of the *Act.*
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of the Employment;* Item C3-18.00, *Personal Acts*.
HISTORY:	This policy replaces former policy item #15.20, *Injuries Following Motions at Work* 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: 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 the employment, and injuries or death that result from pre-existing conditions or diseases.

2. The Act

Section 5(1):

> Where, in an industry within the scope of this Part, personal injury or death arising out of and in the course of the employment is caused to a worker, compensation as provided by 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 employment (which are compensable), and injuries or death resulting from 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 employment. This means that there must have been something in the 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 medical 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 his or her 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 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.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(1) of the *Act.*
CROSS REFERENCES:	Policy item #26.55, *Aggravation of a Disease;* Policy item #114.40, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability;* Policy item #114.41, *Relationship Between Sections 5(5) and 39(1)(e);* Policy item #115.30, *Experience Rating Cost Exclusions.*
HISTORY:	This policy replaces former policy items #15.00, #15.10 and #15.30 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: 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 5(1):

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

Section 96(2):

> Despite subsection (1), at any time, on its own initiative, or on application, the Board may reopen a matter that has been previously decided by the Board or an officer or employee of the Board under this Part if, since the decision was made in that matter,
>
> (a) there has been a significant change in a worker's medical condition that the Board has previously decided was compensable, or
>
> (b) there has been a recurrence of a worker's injury.

POLICY

Item C3-14.00, *Arising Out of and In the Course of the Employment*, is the principal policy that provides guidance in deciding whether or not an injury or death arises out of and in the course of the employment.

Item C3-16.00, *Pre-Existing Conditions or Diseases*, distinguishes between injuries or death resulting from the employment (which are compensable), and injuries or death resulting simply from a 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 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 the 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 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 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 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, *Infectious Agent or Disease Exposures*, is adjudicated as a compensable consequence under Item C3-22.00, *Compensable Consequences*.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

For medical protocols and procedures adopted by the Board related to herniae, see the *Simple Herniorrhaphy Post-op Rehabilitation Guidelines* in the Resources section for Health Care Providers at the www.worksafebc.com website:

http://www.worksafebc.com/health_care_providers/Assets/PDF/post-op_guidelines_hernia.pdf

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EFFECTIVE DATE:	May 1, 2018
AUTHORITY:	Section 5(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 the Employment;* Item C3-16.00, *Pre-Existing Conditions or Diseases;* Item C14-102.01, *Changing Previous Decisions – Reopenings;* Policy item #114.40, *Enhancement of Disability by Reason of Pre-existing Disease, Condition or Disability.*
HISTORY:	This policy was revised to delete section C, Prior Shoulder Dislocations, effective May 1, 2018. This policy replaces former policy items #15.40, #15.50, #15.51, #15.60, and #19.41 of the *Rehabilitation Services & Claims Manual*, Volume II. Housekeeping changes to correct grammar and to add practice references were made to former policy item #15.50 on December 1, 2004. Former policy item #15.50 was last revised on June 1, 2004 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. Former policy item #15.51 was last revised on March 3, 2003 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 5(1):

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

POLICY

A. Introduction

Item C3-14.00, *Arising Out of and In the Course of the Employment*, is the principal policy that provides guidance in deciding whether or not an injury or death arises out of and in the course of the 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 the 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 the employment.

Once it has been established that a worker's injury or death arose out of and in the course of the 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 5(3) of the *Act*. (See Item C3-14.10, *Serious and Wilful Misconduct*.)

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 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 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 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 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, trips over his or her own feet, 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 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 the 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 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 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 employment, the worker may be entitled to compensation. However, if the worker's injury or death is the result of an assault that he or she 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 the 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 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.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(1) of the *Act.*
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of the Employment;* Item C3-14.10, *Serious and Wilful Misconduct;* Item C3-18.00, *Personal Acts.*
HISTORY:	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 5(1):

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

Section 99(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 employment, as described in Item C3-14.00, *Arising Out of and In the Course of the Employment*. 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. The standard of proof is the balance of probabilities and consideration is given to section 99(3) of the *Act*.

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 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 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 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 the 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 optional protection 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.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(1) of the *Act.*
CROSS REFERENCES:	Item C3-20.00, *Employer-Provided Facilities* (C. Lunchrooms).
HISTORY:	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:	This item applies to all 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 5(1):

> Where, in an industry within the scope of this Part, personal injury or death arising out of and in the course of the employment is caused to a worker, compensation as provided by 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 the employment.

Injuries or death resulting from the wearing of clothing or footwear may be considered to arise out of and in the course of the 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 the employment.

It is irrelevant who purchased the clothing or footwear.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(1) of the *Act.*
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of the Employment;* Item C3-18.00, *Personal Acts.*
HISTORY:	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 5(1):

> Where, in an industry within the scope of this Part, personal injury or death arising out of and in the course of the employment is caused to a worker, compensation as provided by 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 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, *Arising Out of and In the Course of the Employment*, 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 the 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 his or her 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 he or she 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 the 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 the 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 the 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 the 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 the 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 the 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 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 his or her own initiative looking for whatever jobs may be found, the person takes the risk of travel upon him or herself.

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 he or she 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 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 the 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 the 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 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 the 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 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 the employment.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(1) of the *Act*.
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of the Employment;* Item C3-18.00, *Personal Acts;* Item C3-20.00, *Employer Provided Facilities*; Item C3-22.10, *Compensable Consequences – Travel.*
HISTORY:	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. Former policy item #18.31 was revised on February 24, 2004 and applied to all decisions made on or after that date, 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 his or her own tools or equipment for employment.

2. The Act

Section 5(1):

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

POLICY

The fact that a worker is required to provide his or her 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 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 the employment.

The carrying or transporting of tools or equipment may be sufficiently connected to the 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 the employment.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(1) of the *Act*.
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of the Employment;* Item C3-19.00, *Work-Related Travel.*
HISTORY:	This policy replaces 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 5(1):

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

POLICY

Item C3-14.00, *Arising Out of and In the Course of the Employment*, is the principal policy that provides guidance in deciding whether or not an injury or death arises out of and in the course of the 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 the employment.

An injury or death occurring in such circumstances generally is not considered to arise out of and in the course of the employment if the injury or death results from exposure to a hazard or risk introduced by a 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 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 the 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 the 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 the 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 the 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 the 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 the 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 the 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 the employment, where such facilities are provided by the employer.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE: July 1, 2010
AUTHORITY: Section 5(1) of the *Act*.
CROSS REFERENCES: Item C3-14.00, *Arising Out of and In the Course of the Employment;*

	Item C3-18.00, *Personal Acts* (A. Lunch, Coffee and Other Breaks); Item C3-19.00, *Work-Related Travel.*
HISTORY:	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:

> "worker" includes
>
> (b) a person who is a learner, although not under a contract of service or apprenticeship, who becomes subject to the hazards of an industry within the scope of Part 1 for the purpose of undergoing training or probationary work specified or stipulated by the employer as a preliminary to employment;

Section 3(6):

> Where the Minister of Education, Skills and Training and the Minister of Labour approve a vocational or training program, and a school or other location as a place of that vocational or training program, the Board may, at the request of either minister, deem any person or class of persons enrolled in the program to be workers of the Crown in right of the Province and compensation under this *Act* is then payable out of the accident fund for injuries arising out of and in the course of training for those workers, but where the injury resulted in a period of temporary disability with no loss of earnings,
>
> (a) a health care benefit only is payable except as provided in paragraph (b); and
>
> (b) where training allowances paid by Canada or the Province are suspended, the Board may, for the period it considers advisable, pay compensation in the amount of the training allowance.

Section 5(1):

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

Section 99(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, *Arising Out of and In the Course of the Employment* 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 the 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 employment. The standard of proof applied is based on a balance of probabilities, and consideration is also given to section 99(3) of the *Act*.

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 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 his or her 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 her or his 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 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 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 his or her 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 the 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 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 employment, and the question to be determined is whether the injury or death arose out of and in the course of the education or training itself:

- Board-recognized vocational or training programs under section 3(6) of the *Act*.
- Vocational rehabilitation programs undertaken as part of a Board-approved rehabilitation plan (see Items C11-88.50, *Vocational Rehabilitation – Formal Training* and C3-22.00, *Compensable Consequences*).
- Pre-employment training or probationary work undertaken by a person not under contract of service or apprenticeship that was specified or stipulated by an employer as a preliminary to employment and which subjects the person to the hazards of an industry within the scope of Part 1 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 employment as to be considered part of the 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*.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(1) of the *Act*.
CROSS REFERENCES:	Policy item #7.10, *Members of Fire Brigades;* Item C3-12.20, *Commencement and Termination of the Employment Relationship;* Item C3-14.00, *Arising Out of and In the Course of the Employment;* Item C11-88.50, *Vocational Rehabilitation – Formal Training;* Policy item #115.30, *Experience Rating Cost Exclusions.*
HISTORY:	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. Former policy item #20.20 was amended June 1, 2004 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 section 5(1) test. Changes to both former policies applied to all injuries on or after June 1, 2004.
APPLICATION:	This item applies to all 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 5(1):

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

Section 21:

> …
>
> (6) Health care furnished or provided … must at all times be subject to the direction, supervision and control of the Board … and all questions as to the necessity, character and sufficiency of health care to be furnished must be determined by the Board. …
>
> (7) Without limiting the power of the Board under this section to supervise and provide for the furnishing of health care in every case where it considers the exercise of that power is expedient, the Board must permit health care to be administered, so far as the selection of a physician or qualified practitioner is concerned, by the physician or qualified practitioner who may be selected or employed by the injured worker.

Section 35.1:

> …
>
> (4) Subject to subsections (5) to (8), if a worker's permanent disability first occurs on or after [June 30, 2002], as a result of an injury that occurred

> before [June 30, 2002], this *Act*, as amended by the *Workers Compensation Amendment Act, 2002*, applies to the permanent disability.
>
> …
>
> (8) If a worker has, on or after [June 30, 2002], a recurrence of a disability that results from an injury that occurred before [June 30, 2002], the Board must determine compensation for the recurrence based on this *Act*, as amended by the *Workers Compensation Amendment Act, 2002*.

Section 96(2):

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

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 35.1(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, *Scope of Volumes I and II in Relation to Benefits for Injured Workers*, of Volume I or 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 the 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, *Changing Previous Decisions – Reopenings*.)

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 39(1)(e).

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 the 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 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 a permanent disability award. Such exercises are usually for the purpose of preventing further problems rather than for treating an existing condition. Compensation is not payable in respect of preventive measures.

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 the 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.

PRACTICE

For any relevant PRACTICE information, please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(1) of the *Act*.
CROSS REFERENCES:	Policy item #1.03, *Scope of Volumes I and II in Relation to Benefits for Injured Workers*; Item C3-14.00, *Arising Out of and In the Course of the 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*;

Policy item #115.30, *Experience Rating Cost Exclusions*;
Policy item #115.34, *Experience Rating Exclusions for Certain Compensable Consequences.*

HISTORY: 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.

Former policy items #22.00, #22.10, #22.11, and #22.21 were amended effective February 1, 2004 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: This item applies to all 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 5(1):

> Where, in an industry within the scope of this Part, personal injury or death arising out of and in the course of the employment is caused to a 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.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(1) of the *Act*.
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of the Employment;* Item C3-19.00, *Work-Related Travel;* Item C3-22.00, *Compensable Consequences;* Policy item #115.34, *Experience Rating Exclusions for Certain Compensable Consequences*.
HISTORY:	This policy replaces former policy item #22.15 of the *Rehabilitation Services & Claims Manual*, Volume II. Former policy item #22.15 was amended effective February 1, 2004 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 5(1):

> Where, in an industry within the scope of this Part, personal injury or death arising out of and in the course of the employment is caused to a worker, compensation as provided by 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 medical 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 policy item #39.02, *Chronic Pain*.

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 his or her 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 29 or 30 of the *Act*.

Where chronic pain is considered by the Board to become permanent, entitlement to permanent partial disability benefits may be considered under section 23 of the *Act*.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(1) of the *Act*.
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of the Employment;* Item C3-22.00, *Compensable Consequences;* Item C3-22.30, *Compensable Consequences – Psychological Impairment;* Chapter 5 – Wage-Loss Benefits; Chapter 6 – Permanent Disability Awards; Policy item #39.02, *Chronic Pain;* Chapter 11 – Vocational Rehabilitation; Item C11-88.00, *Vocational Rehabilitation Nature and Extent of Programs and Services.*
HISTORY:	This policy replaces former policy item #22.35 of the *Rehabilitation Services & Claims Manual*, Volume II. Former policy item #22.35 was created January 1, 2003 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:	This item applies to all 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 5(1):

> Where, in an industry within the scope of this Part, personal injury or death arising out of and in the course of the employment is caused to a worker, compensation as provided by 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 5(1) or occupational disease accepted under section 6(1). When the psychological impairment is temporarily disabling, the worker is also entitled to temporary wage-loss benefits under section 29 or 30 of the *Act*.

When the psychological impairment becomes permanent, it will be necessary to determine whether there is entitlement to a permanent disability award. The decision-

making procedure for assessing entitlement to a permanent disability award for psychological impairment is found in policy item #39.01, *Decision-Making Procedure under Section 23(1)*.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 5(1) of the *Act*.
CROSS REFERENCES:	Item C3-12.00, *Personal Injury;* Item C3-14.00, *Arising Out of and In the Course of the Employment;* Item C3-22.00, *Compensable Consequences;* Item C3-22.20, *Compensable Consequences – Pain and Chronic Pain;* Policy item #39.01, *Decision-Making Procedure under Section 23(1);* Chapter 5 – Wage Loss Benefits; Policy item #73.20, *Duration of Medical Assistance.*
HISTORY:	This policy replaces 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 5(1):

> Where, in an industry within the scope of this Part, personal injury or death arising out of and in the course of the employment is caused to a worker, compensation as provided by 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 the 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 a significant cause of the subsequent disease or condition, then the subsequent disease or condition is sufficiently connected to the compensable injury as to be considered to arise out of and in the course of the 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 suicide would have been unlikely to occur if there had been no employment-related injury, then it is likely to be considered sufficiently connected to the employment-related injury as to also be compensable. If the suicide was something which might well have occurred in any event, then it will not be considered sufficiently connected to the employment-related injury and will not be

covered. 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. Cancer

In claims where trauma is alleged to be the cause of cancer, the following five criteria should be satisfied before a cancer can be considered to be traumatically induced.

1. Authenticity and adequacy of trauma.
2. Previous integrity of the wounded part.
3. Origin of tumour at exact point of injury.
4. Reasonable time limit between injury and time of appearance of tumour.
5. Positive diagnosis of the presence and nature of the tumour.

Reviews of the medical literature have been completed to ascertain whether or not there is new evidence to associate trauma as a causal agent in cancer.

Except in the case of skin cancer, there is little firm evidence to associate trauma with cancer as an etiologic agent. Although there is general recognition of what has been called "traumatic determinism", i.e. that an injury may call the person's attention to a pre-existing tumour, there is no known causal relationship between trauma and bone cancer.

C. 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, *Potentially Addictive Drugs*.

Compensation for alcoholism as an occupational disease is addressed in policy item #32.15, *Alcoholism*.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	January 1, 2014
AUTHORITY:	Section 5(1) of the *Act*.
CROSS REFERENCES:	Item C3-14.00, *Arising Out of and In the Course of the Employment;* Item C3-16.00, *Pre-Existing Conditions or Diseases;* Item C3-22.00, *Compensable Consequences;* Item C3-22.30, *Compensable Consequences – Psychological Impairment;* Policy item #32.15, *Alcoholism;* Item C10-80.00, *Potentially Addictive Drugs.*
HISTORY:	Consequential amendments arising from changes to Chapter 10, *Medical Assistance, Rehabilitation Services and Claims Manual,* were made effective January 1, 2015. This policy was revised to delete section B, Multiple Sclerosis, effective January 1, 2014. 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: This item applies to all claims for injuries occurring on or after January 1, 2014.

RE:	Replacement and Repair of Personal Possessions – Section 21(8)	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 21(8) to federal government employees.

2. The Act

Section 1:

> "accident" includes a wilful and intentional act, not being the act of the worker, and also includes a fortuitous event occasioned by a physical or natural cause;

Section 21(8):

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

POLICY

A. Authority under Section 21(8)

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 21(8) 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 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 21(8), 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 5(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.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 21(8) of the *Act*.
CROSS REFERENCES:	Item C3-23.10, *Section 21(8)(a) – Artificial Appliances;* Item C3-23.20, *Section 21(8)(b) – Eyeglasses, Dentures and Hearing Aids;* Item C3-23.30, *Section 21(8) – Wage Loss Benefits During the Replacement or Repair Period.*
HISTORY:	This policy replaces 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 21(8)(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:

> "accident" includes a wilful and intentional act, not being the act of the worker, and also includes a fortuitous event occasioned by a physical or natural cause;

Section 21(8):

> The Board may assume the responsibility of replacement and repair of
>
> (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 of the worker;

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 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 21(8) if it had the potential or reasonable probability of causing harm or personal injury to the worker.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 21(8) of the *Act*.
CROSS REFERENCES:	Item C3-14.20, *Accident – Section 5(4) Presumption;* Item C3-23.00, *Replacement and Repair of Personal Possessions – Section 21(8);* Item C3-23.20, *Section 21(8)(b) – Eyeglasses, Dentures and Hearing Aids;* Item C3-23.30, *Section 21(8) – Wage Loss Benefits During the Replacement or Repair Period.*

HISTORY: Incorporates concepts from former policy items #23.30 and #23.40 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:	Section 21(8)(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:

> "accident" includes a wilful and intentional act, not being the act of the worker, and also includes a fortuitous event occasioned by a physical or natural cause;

Section 21(8):

> The Board may assume the responsibility of replacement and repair of
>
> …
>
> (b) eyeglasses, dentures and hearing aids broken as a result of an accident arising out of and in the course of employment if that breakage is accompanied by objective signs of personal injury, or, where there is no personal injury, if 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 5(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 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 21(8) 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.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 21(8) of the *Act*.
CROSS REFERENCES:	Item C3-12.00, *Personal Injury;* Item C3-14.20, *Accident – Section 5(4) Presumption;* Item C3-23.00, *Replacement and Repair of Personal Possessions – Section 21(8);* Policy item #97.00, *Evidence*; Policy item #97.10, *Evidence Evenly Weighted;* Policy item #97.20, *Presumptions;* Policy item #97.30, *Medical Evidence*; Policy item #97.31, *Matter Requiring Medical Expertise;* Policy item #97.32, *Statement of Worker about His or Her Own Condition;* Policy item #97.33, *Statement by Lay Witness on Medical Question;* Policy item #97.34, *Conflict of Medical Opinion;* Policy item #97.35, *Termination of Benefits;* Policy item #97.40, *Disability Awards;* Policy item #97.50, *Rumours and Hearsay;* Policy item #97.60, *Lies*.

HISTORY:	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 21(8) – 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 5(1):

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

Section 21(8):

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

Section 29(1):

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

Section 30(1):

> … 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 21(8) 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 he or she 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.

PRACTICE

For any relevant PRACTICE information please consult the WorkSafeBC website at www.worksafebc.com.

EFFECTIVE DATE:	July 1, 2010
AUTHORITY:	Section 21(8) of the *Act*.
CROSS REFERENCES:	Item C3-23.00, *Replacement and Repair of Personal Possessions – Section 21(8);* Item C3-23.10, *Section 21(8)(a) – Artificial Appliances;* Item C3-23.20, *Section 21(8)(b) – Eyeglasses, Dentures and Hearing Aids;* Policy item #33.00, *Introduction.*
HISTORY:	This policy replaces 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.

CHAPTER 4

COMPENSATION FOR OCCUPATIONAL DISEASE

#25.00 INTRODUCTION

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

Most compensation cases involve a personal injury (covered in Chapter 3) where it can readily be determined whether the event or series of events leading to such injury arose out of and in the course of employment. The cause of disease, by its nature, is often more difficult to determine. A common difficulty is distinguishing between an injury and a disease (the difference is discussed in Item C3-12.00, *Personal Injury*). Even when medical science has identified the cause of a disease in a general sense, it may be difficult to establish with any degree of certainty how and when a worker contracted or developed a disease. Further, workers' compensation does not extend to all diseases, rather only to those that are due to a worker's employment. In these circumstances, determining the extent to which a worker's employment had a role in producing the disease becomes a critical or central issue.

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

#25.10 Legislative Requirements

Section 6(1) provides:

Where

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

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

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

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

1. The worker must be suffering (or in the case of a deceased worker have suffered) from a disease designated or recognized by the Board as an "occupational disease";

2. The disease suffered by the worker must be or have been "due to the nature of any employment" in which the worker was employed; and

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

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

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

#26.00 THE DESIGNATION OR RECOGNITION OF AN OCCUPATIONAL DISEASE

Section 1 of the *Act* defines "occupational disease" as

(a) a disease mentioned in Schedule B,

(b) a disease the Board may designate or recognize by regulation of general application,

(c) a disease the Board may designate or recognize by order dealing with a specific case, and

(d) the disease referred to in section 6.1(1.1) or (7) or a disease prescribed by regulation for the purposes of section 6.1(2), 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,

and "disease" includes disablement resulting from exposure to contamination.

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, suffered by workers who are covered by the *Act*.

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.

EFFECTIVE DATE:	May 1, 2017
HISTORY:	May 1, 2017 – Update policy to add a reference to the firefighters' presumption in the definition of "occupational disease".
APPLICATION:	Applies on or after May 1, 2017.

#26.01 Recognition by Inclusion in Schedule B

Any disease listed in the first column of Schedule B 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 B 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 B is set out in Appendix 2. The application of Schedule B is covered in policy item #26.21. The amendment of Schedule B is covered in policy item #26.60.

#26.02 Recognition under Section 6(4.2)

Section 6(4.2) provides that:

> . . . 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.

This provision gives the Board substantial flexibility in its designation or recognition of an occupational disease other than by listing it in Schedule B.

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.

This section 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 B (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:	December 11, 2013
HISTORY:	This policy change removes reference to *Workers Compensation Reporter* series Decision No. 231, (1977) 3 W.C.R. 87 and reflects the current medical/scientific evidence regarding osteoarthritis of the first carpo-metacarpal joint of both thumbs in physiotherapists. July 16, 2002 – Revised to reflect change of section numbering in the *Act* and housekeeping changes.
APPLICATION:	This policy applies to all claims where the date of disablement is on or after December 11, 2013.

#26.03 Recognition by Regulation of General Application

The Board may designate or recognize a disease as an occupational disease "by regulation of general application" (section 1). In these circumstances, the Board designates or recognizes a disease as an occupational disease but without specifying that it is peculiar to or characteristic of a particular process, trade or occupation. The desired institutional memory is thus less specific. The Board has designated or recognized the following as occupational diseases by regulation:

Bronchitis
Bursitis (other than the forms of bursitis mentioned in Item 12 of Schedule B 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 13 of Schedule B 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

It is important to distinguish between designation or recognition of an occupational disease under section 6(4.2) where a particular process, trade or occupation is specified or by regulation of general application, and the addition of a disease to Schedule B under section 6(4.1). Where the Board concludes that a disease is more likely to occur in connection with a particular employment covered by the *Act* than elsewhere, it may be added to Schedule B (see policy item #26.01, *Recognition by Inclusion in Schedule B*). On the other hand, where the Board concludes that a disease is sometimes due to the nature of a particular employment covered by the *Act*, but it does not appear that the disease is more likely to occur in connection with that employment than elsewhere (it is not something specific to that employment), the Board may designate or recognize the disease under section 6(4.2) where a particular process, trade or occupation is specified, or by regulation of general application without the rebuttable presumption afforded by inclusion in Schedule B.

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

The authority under the *Act* to designate or recognize a disease by regulation under sections 6(4.1) and 6(4.2) rests with the Board of Directors.

EFFECTIVE DATE:	March 1, 2015
AUTHORITY:	Section 1 of the *Act.*
CROSS REFERENCES:	Policy item #26.00, *The Designation or Recognition of an Occupational Disease*; Policy item #26.01, *Recognition by Inclusion in Schedule B*; Policy item #26.02, *Recognition under Section 6(4.2)*.
HISTORY:	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.
APPLICATION:	This item applies to all decisions made on or after March 1, 2015.

#26.04 Recognition by Order Dealing with a Specific Case

The lack of prior designation or recognition by the Board of a disease as an occupational disease by any of the means specified in policy items #26.01, *Recognition by Inclusion in Schedule B*, #26.02, *Recognition under 6(4.2)*, or #26.03, *Recognition by Regulation of General Application*, does not mean a claim for such disease will not be considered on its merits. Such disease may not have been previously designated or recognized due to weak or a complete absence of medical and scientific information which causally associates such disease with employment. If the merits and justice of an individual claim for such a disease warrant its recognition as an occupational disease, the Board may do so "by order dealing with a specific case" (section 1).

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

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

The Board upon investigating an individual claim may find that the condition suffered by the worker is not one listed in the first column of Schedule B, nor is it one which has been previously designated or recognized by the Board as an occupational disease under section 6(4.2), or by regulation of general application. If the Board concludes, after seeking appropriate input from both the worker (or their legal representative) and the employer (if a specific employer is

identified) that the facts warrant recognition of the worker's condition as an occupational disease, the Board officer will refer the claim with a recommendation to that effect to a panel made up of a Client Services Manager, (referred to in this section as the "Manager", and a Board Medical Advisor (referred to in this section as the "Medical Advisor").

If, however, after seeking such input from the worker and employer, the Board 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 he or she considers appropriate, will determine whether the condition reported is one which should be recognized by the Board as an occupational disease for the purposes of that claim. If so, he or she will make an order to that effect which is recorded on the claim. The Manager will keep a record of all such referrals under this section.

If, after considering a referral under this section, the Manager concludes that the reported condition might not be recognized as an occupational disease, the worker (or in the case of a deceased worker, their 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, he or she will ensure that the Client Services Manager, Occupational Disease Services is provided with written notice of any decisions under policy item #26.04, *Recognition by Order Dealing with a Specific Case*.

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

EFFECTIVE DATE:	March 1, 2015
AUTHORITY:	Section 1 of the *Act.*
CROSS REFERENCES:	Policy item #26.00, *The Designation or Recognition of an Occupational Disease*; Policy item #26.01, *Recognition by Inclusion in Schedule B*; Policy item #26.02, *Recognition under Section 6(4.2)*.
HISTORY:	Language added stating that an occupational disease may be recognized by regulation of general application. Change also made 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. Minor changes to add policy item titles. June 1, 2009 – Deleted references to Board officers. October 1, 2007 – Revised to delete references to memos and memorandums. March 3, 2003 – consequential changes as to references to review.
APPLICATION:	This item applies to all decisions made on or after March 1, 2015.

#26.10 Suffers from an Occupational Disease

Part of the first requirement for compensability is that the worker suffers from, or in the case of a deceased worker the death was caused by, an occupational disease. Confirming the diagnosis of many occupational diseases may be difficult. This is particularly so for poisoning by some of the metals and compounds listed in Schedule B, the symptoms of which may be similar to the symptoms caused by common complaints that produce fatigue, nausea, headache and the like.

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

#26.20 Establishing Work Causation

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

There are two approaches to establishing work causation: presumptions under the *Act* and non-scheduled recognition and onus of proof.

EFFECTIVE DATE:	May 1, 2017
HISTORY:	May 1, 2017 – Update policy to identify the two approaches to establishing work causation.
APPLICATION:	Applies on or after May 1, 2017.

#26.21 Schedule B Presumption

Section 6(3) provides:

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

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

The fundamental purpose of Schedule B is to avoid the repeated effort of producing and analyzing medical and other evidence of work-relatedness for a disease where research has caused the Board to conclude that such disease is specific to a particular process, agent or condition of employment (see policy item #26.01). Once included in Schedule B, 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 B 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 B and the issue of work-relatedness must be determined on a case-by-case basis (see policy item #26.23).

If at the time a worker becomes disabled by a disease listed in Schedule B, or if immediately before such date, such worker was employed in the process or industry described in the second column of the Schedule opposite to such disease, the worker is entitled to a presumption that the disease was caused by their employment, “unless the contrary is proved”. This presumption applies whether the disease manifests itself while the worker is at work, at home, while away on holidays, or elsewhere. The words “immediately before” used in section 6(3) 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 B 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 policy item #26.23.

Inclusion of the words “unless the contrary is proved” in section 6(3) 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 disease, they 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. This is the same basic standard of proof applicable in the workers’ compensation system. 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 gathering and weighing of evidence generally is covered in policy items #97.00 through #97.60.

Difficulties may arise in determining whether the worker was employed in the process or industry described in the second column. 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.

EFFECTIVE DATE:	May 1, 2017
HISTORY:	May 1, 2017 – Consequential amendment made on May 1, 2017 to reflect renumbering of policy item #26.23 (formerly #26.22). June 1, 2004 – Statements adopting a broad interpretation of the phrase "immediately before" have been deleted.
APPLICATION:	Applies on or after May 1, 2017.

#26.22 Additional Presumptions in the Workers Compensation Act

The *Act* provides the following additional presumptions:

- Firefighters' occupational disease or personal injury presumption (see section 6.1 of the *Act)*;
- Communicable disease presumption (see section 6.2 of the *Act)*; and
- Mental disorder presumption (see section 5.1 of the *Act*).

EFFECTIVE DATE:	July 23, 2018
HISTORY:	Consequential amendments arising from the Bill 9 amendments to section 5.1 of the *Act*, were made effective July 23, 2018. May 1, 2017 – Adding to policy a reference to the firefighters' presumption and communicable disease presumption provided in the *Act*.
APPLICATION:	Applies on or after July 23, 2018

#26.23 Non-Scheduled Recognition and Onus of Proof

In some cases a worker may suffer an occupational disease not listed in Schedule B. In other cases a worker may suffer from an occupational disease listed in Schedule B but was not employed in the process or industry described opposite to it in the Schedule. In some cases a worker may suffer a disease not previously designated or recognized by the Board as an occupational disease. Here, 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 6(3) are not met.

For this purpose the Board will conduct a detailed investigation of the worker's circumstances including information about the worker, their diagnosed condition, and their workplace activities. The Board is seeking to gather evidence that tends to establish that there is a causative connection between the work and the disease. The Board will also seek out or may be presented with evidence which tends to show there is no causative connection. The gathering and weighing of evidence generally is covered in policy items #97.00 through #97.60. The Board

is to examine the evidence to see whether it is sufficiently complete and reliable to arrive at a sound conclusion with confidence. If not, the Board should consider what other evidence might be obtained, and must take the initiative in seeking further evidence. After that has been done, if, on weighing the available evidence, there is then a preponderance in favour of one view over the other, that is the conclusion that must be reached. 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 his or her case. All that is needed is for the worker to describe his or her personal experience of the disease and the reasons why they suspect 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, their 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 his or her own 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 policy item #97.10, a worker is also assisted in establishing a relationship between the disease and the work by section 99 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 upon the merits and justice of the case, but in so doing the Board must apply a policy of the board of directors that is applicable in 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.

Therefore if the weight of the evidence suggesting the disease was caused by the employment is roughly equally balanced with evidence suggesting non-employment causes, the issue of causation will be resolved in favour of the worker. This provision does not come into play where the evidence is not evenly weighted on an issue.

If the Board has no or insufficient positive evidence before it that tends to establish that the disease is due to the nature of the worker's employment, the Board's only possible decision is to deny the claim.

EFFECTIVE DATE:	May 1, 2017
HISTORY:	May 1, 2017 – Renumbered from #26.22. June 1, 2009 – Delete references to Board officers. March 3, 2003 – New wording of section 99
APPLICATION:	Applies on or after May 1, 2017.

#26.30 Disabled from Earning Full Wages at Work

No compensation other than health care benefits are payable to a worker who suffers from an occupational disease (with the exception of silicosis, asbestosis, or pneumoconiosis and claims for hearing loss to which section 7 of the *Act* apply) unless the worker "is thereby disabled from earning full wages at the work at which the worker was employed". (3) No compensation is payable in respect of a deceased worker unless his or her death was caused by an occupational disease (also see section 6(11) of the *Act*).

Health care benefits may be paid to a worker who suffers from an occupational disease even though the worker is not thereby disabled from earning full wages at the work at which he or she was employed.

There is no definition of "disability" in the *Act.* The phrase "disabled 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 he or she was disabled by the occupational disease. This means that there must be some loss of earnings from such regular employment as a result of the disabling affects of the disease, and not just an impairment of function. For example, disablement for the purposes of section 6(1) may result from:

- an absence from work in order to recover from the disabling affects of the disease;
- an inability to work full hours at such regular employment due to the disabling affects 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 affects of the employment.

A worker who must take time off from his or her usual employment to attend medical appointments is not considered disabled by virtue of that fact alone. However, income loss payments may be made 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 policy item #32.55.

#26.50 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 is suffering from 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 evidence must establish that the work activity brought about a disability that would probably not otherwise have occurred, or that the work activity significantly advanced the development of a disability that would otherwise probably not have occurred until later.

For example, osteoarthritis in the spine, rheumatoid arthritis, and degenerative disc disease have not been designated or recognized under policy items #26.01, #26.02, or #26.03 as occupational diseases. (4), (5)

#26.55 Aggravation of a Disease

Where a worker has a pre-existing disease which is aggravated by work activities to the point where the worker is thereby disabled, 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 rendered the disease disabling and pay compensation. Evidence that the pre-existing disease has been significantly accelerated, activated, or advanced more quickly than would have occurred in the absence of the work activity, is confirmation that a compensable aggravation has resulted from the work.

This must be distinguished from the situation where work activities have the effect of drawing to the attention of the worker the existence of the pre-existing disease without significantly affecting the course of such disease. For example, a worker who experiences hand or arm pain due to an arthritis condition affecting that limb will not be entitled to compensation simply because they experience pain in that limb from performing employment activities. Similarly, a worker with a history of intermittent pain and numbness in a hand/wrist due to a pre-existing median nerve entrapment (carpal tunnel syndrome) will not be entitled to compensation just because their work activities also produce the same symptoms. To be compensable as a work-related aggravation of a disease, the evidence must establish that the employment activated or accelerated the pre-existing disease to the point of disability in circumstances where such disability would not have occurred but for the employment.

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 his or her back while performing a series of awkward lifts at work may suffer an aggravation to 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 39(1)(e) of the *Act*. If a permanent disability results, consideration is also given to proportionate entitlement under section 5(5) of the *Act*. (See policy items #114.40, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*, and #114.41, *Relationship Between Sections 5(5) and 39(1)(e)*.)

EFFECTIVE DATE: July 1, 2010
APPLICATION: Applies on or after July 1, 2010

#26.60 Amending Schedule B

Section 6(4.1) of the *Act* provides:

> The Board may, by regulation,
>
> (a) add to or delete from Schedule B a disease that, in the opinion of the Board, is an occupational disease,
>
> (b) add to or delete from Schedule B a process or an industry, and
>
> (c) set terms, conditions and limitations for the purposes of paragraphs (a) and (b).

This provision gives the Board substantial flexibility in its ability to add to or delete from the list of diseases designated or recognized in Schedule B, 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 the second column.

Claims for all of the diseases in Schedule B 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 the second column of Schedule B, but without the benefit of the presumption set out in section 6(3) of the *Act*. See policy item #26.23.

EFFECTIVE DATE:	May 1, 2017
HISTORY:	May 1, 2017 – Consequential amendment made on May 1, 2017 to reflect renumbering of policy item #26.23 (formerly #26.22).
APPLICATION:	Applies on or after May 1, 2017.

#27.00 ACTIVITY-RELATED SOFT TISSUE DISORDERS (“ASTDS”) OF THE LIMBS

1. Definition of ASTD

The terms “cumulative trauma disorder”, “repetitive strain injury”, “repetitive motion disorder”, “occupational overuse syndrome”, “occupational cerviobrachial 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 which may or may not be caused or aggravated by employment activities.

2. 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 B (see policy item #26.01, *Recognition by Inclusion in Schedule B*) or by regulation (see policy item #26.03, *Recognition by Regulation of General Application*).

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, *Personal Injury*). 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 this chapter.

3. 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.

4. Establishing Work Causation

As with other occupational diseases, the Board determines whether a worker's ASTD was caused or aggravated by the worker's employment (see policy item #26.20, *Establishing Work Causation*).

Where the strength of association between a process or industry and a specific ASTD is strong, it may be included in Schedule B with the benefit of the rebuttable presumption provided for in section 6(3) of the *Act*. For ASTDs that are not included in Schedule B, the Board may assess work causation under section 6(1) of the *Act* based on the circumstances of the individual case, with consideration of risk factors set out in policy, and the current medical/scientific evidence.

When 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; and

- ASTDs are often caused by exposure to a combination of risk factors, rather than just one risk factor.

5. 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. 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.

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.

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.

EFFECTIVE DATE:	March 1, 2015
AUTHORITY:	Section 6(1) and 6(3) of the *Act.*
CROSS REFERENCES:	Item C3-12.00, *Personal Injury;* Policy item #26.01, *Recognition by Inclusion in Schedule B;* Policy item #26.03, *Recognition by Regulation of General Application;* Policy item #26.20, *Establishing Work Causation.*
HISTORY:	This policy provides guidance on adjudicating ASTDs generally. It incorporates 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 provides guidance on adjudicating ASTDs as either personal injuries or occupational diseases. The definitions of the terms nerve entrapment and tendinopathy are included. Guidance on factors relevant to establishing work causation of ASTDs and risk factors generally are included.
APPLICATION:	This item applies to all decisions made on or after March 1, 2015.

#27.10 ASTDs Recognized by Inclusion in Schedule B

The following ASTDs are recognized as occupational diseases by inclusion in Schedule B: hand-wrist tendinopathy (policy item #27.11), shoulder tendinopathy and shoulder bursitis (policy item #27.12), knee bursitis (policy item #27.13), and hand-arm vibration syndrome (policy item #27.14).

The general application of the Schedule B presumption for establishing work causation is discussed in policy item #26.21, *Schedule B Presumption*.

EFFECTIVE DATE:	March 1, 2015
AUTHORITY:	Section 1 of the *Act* and Schedule B of the *Act.*
CROSS REFERENCES:	Policy item #26.01, *Recognition by Inclusion in Schedule B of the Act;* Policy item #26.21, *Schedule B Presumption;* Policy item #27.11, *Hand-Wrist Tendinopathy;* Policy item #27.12, *Shoulder Tendinopathy and Shoulder Bursitis*; Policy item #27.13, *Knee Bursitis;* Policy item #27.14, *Hand-Arm Vibration Syndrome.*
HISTORY:	Changes made for clarity and to reflect the new numbering of the ASTD policies and terminology.
APPLICATION:	This item applies to all decisions made on or after March 1, 2015.

#27.11 Hand-Wrist Tendinopathy

Schedule B lists “hand-wrist tendinopathy” as an occupational disease (Schedule B item 13(a)). Schedule B 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(s) to perform a task or series of tasks that involve any two of the following:
>
> (1) frequently repeated motions or muscle contractions that place strain on the affected tendon(s);
>
> (2) significant flexion, extension, ulnar deviation or radial deviation of the affected hand or wrist;
>
> (3) forceful exertion of the muscles utilized in handling or moving tools or other objects with the affected hand or wrist;
>
> 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.

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 B in connection with hand-wrist tendinopathy.

1. Frequently Repeated

A worker who is performing the same work task(s) again and again without interruption or rest between, is likely required to perform “frequently repeated motions or muscle contractions”.

Generally, tasks that place strain on the affected tendon(s), 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.

The Board assesses whether a worker was performing "frequently repeated motions or muscle contractions", in the context of each individual case, for tasks that involve shorter work cycle frequencies or greater periods of rest and recovery time than referred to above.

2. Significant Flexion, Extension, Ulnar Deviation or Radial Deviation

"Significant flexion, extension, ulnar deviation or radial deviation of the affected hand or wrist" means:

- 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 25 degrees of extension from functional neutral (20 degrees from anatomical neutral);

- 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.

3. Forceful Exertion

"Forceful exertion of the muscles utilized in handling or moving tools or other objects with the affected hand or wrist" means 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 (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 circumstances of an individual case.

4. Significant Component of the Employment

Use in Schedule B item 13(a) of the words "where such activity represents a significant component of the employment" means that the worker has been exposed to the processes described in paragraphs (1), (2), and (3) of item 13(a) 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 13(a) do not amount to "a significant component of the employment".

For claims that do not meet the descriptions contained in item 13(a) of Schedule B, see policy item #27.20, *ASTDs Listed in Schedule B Where No Presumption Applies*.

EFFECTIVE DATE:	March 1, 2015
AUTHORITY:	Section 1, 6(3), and Schedule B of the *Act.*
CROSS REFERENCES:	Policy item #26.01, *Recognition by Inclusion in Schedule B;* Policy item #27.20, *ASTDs Listed in Schedule B Where No Presumption Applies;* Policy item #26.21, *Schedule B Presumption.*
HISTORY:	Reference to specific text of the Schedule B presumption, along with definitions of tendinopathy and hand-wrist tendinopathy included for clarity. Definition of hand-wrist tendinopathy updated. Description of flexion and extension clarified.
APPLICATION:	This item applies to all decisions made on or after March 1, 2015.

#27.12 Shoulder Bursitis and Shoulder Tendinopathy

Schedule B lists “shoulder bursitis” (Schedule B item 12(b)) and “shoulder tendinopathy” (Schedule B item 13(b)) as occupational diseases. Schedule B 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 60 degrees 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 B in connection with shoulder bursitis (Schedule B item 12(b)) and shoulder tendinopathy (Schedule B item 13(b)).

1. 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 60 degrees”, 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 60 degrees);
- 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 60 degrees" 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.

The Board assesses whether a worker was performing "frequently repeated or sustained abduction or flexion of the shoulder joint greater than 60 degrees" in the context of each individual case for tasks that involve less frequent repetition or greater periods of rest and recovery time than referred to above.

2. Sustained Abduction or Flexion of the Shoulder Joint

"Sustained abduction or flexion of the shoulder joint" means that the shoulder joint is held in a static position of abduction or flexion greater than 60 degrees. The greatest pressure is placed on the shoulder bursa when there is between 60 and 120 degrees of abduction or flexion (0 degrees 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".

3. Significant Component of the Employment

Use in Schedule B items 12(b) and 13(b) of the words "where such activity represents a significant component of the employment" means 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 12(b) or 13(b) of Schedule B, see policy item #27.20, *ASTDs Listed in Schedule B Where No Presumption Applies*.

EFFECTIVE DATE:	March 1, 2015
AUTHORITY:	Section 1, 6(3), and Schedule B of the *Act.*
CROSS REFERENCES:	Policy item #26.01, *Recognition by Inclusion in Schedule B;* Policy item #27.20, *ASTDs Listed in Schedule B Where No Presumption Applies;* Policy item #26.21, *Schedule B Presumption.*
HISTORY:	Reference to specific text of the Schedule B presumption, along with updated definitions of shoulder tendinopathy and shoulder bursitis included for clarity. Incorporates terms from policy item #27.00. Former policy items #27.11, *Bursitis*, and #27.12, *Tendinitis and Tenosynovitis*, of the *Rehabilitation Services & Claims Manual*, Volume II are combined into this one policy because the two conditions share the same risk factors.
APPLICATION:	This item applies to all decisions made on or after March 1, 2015.

#27.13 Knee Bursitis

Schedule B lists “knee bursitis (inflammation of the prepatellar, suprapatellar, or superficial infrapatellar bursa)” as an occupational disease (Schedule B item 12(a)). Schedule B 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 there is repeated jarring impact against, or where 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.

“Significant periods of kneeling”, as used in Schedule B in connection with knee bursitis, means 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 12(a) of Schedule B, see policy item #27.20, *ASTDs Listed in Schedule B Where No Presumption Applies*.

EFFECTIVE DATE:	March 1, 2015
AUTHORITY:	Section 1, 6(3), and Schedule B of the *Act.*
CROSS REFERENCES:	Policy item #26.01, *Recognition by Inclusion in Schedule B;* Policy item #27.20, *ASTDs Listed in Schedule B Where No Presumption Applies;* Policy item #26.21, *Schedule B Presumption*.
HISTORY:	Reference to specific text of the Schedule B presumption, along with updated definition of bursitis included for clarity. For increased accuracy, the wording of the Schedule B presumption is modified to refer to the "involved bursa" instead of the "affected knee".
APPLICATION:	This item applies to all decisions made on or after March 1, 2015.

#27.14 Hand-Arm Vibration Syndrome (HAVS)

Schedule B lists "hand-arm vibration syndrome" as an occupational disease (Schedule B item 16). Schedule B 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 which cause the transfer of significant vibration to the hand-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 following represents a list of the most important risk factors relevant to the adjudication of all claims for HAVS.

1. Dose

This 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. It should be noted, however, that the condition could occur with exposures less than 1000 hours if the intensity of the exposure is significant. Such cases are considered on their own merits.

2. Significant Vibration to the Hand-Arm

Use of the words “significant vibration” in Schedule B 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 having regard to the evidence available.

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-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.

3. 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 diseases involve an initial period of temporary disability during which temporary total or temporary partial disability benefits are paid. The physical impairment of the worker will usually improve in time until it disappears entirely or becomes permanent. However, in the case of some 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 temporary disability benefits are payable. HAVS is one of these diseases. Permanent disability awards are payable in respect of the disabilities caused by these diseases only once a specified minimum level of impairment is reached. Temporary disability 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 16 of Schedule B, see policy item #27.20, *ASTDs Listed in Schedule B Where No Presumption Applies*.

EFFECTIVE DATE:	March 1, 2015
AUTHORITY:	Section 1, 6(3), and Schedule B of the *Act.*
CROSS REFERENCES:	Policy item #26.01, *Recognition by Inclusion in Schedule B;* Policy item #27.20, *ASTDs Listed in Schedule B Where No Presumption Applies;* Policy item #26.21, *Schedule B Presumption*.
HISTORY:	Minor changes for clarity.
APPLICATION:	This item applies to all decisions made on or after March 1, 2015.

#27.20 ASTDs Listed in Schedule B Where No Presumption Applies

Where a worker suffers from an ASTD listed in Schedule B**,** but the worker was not employed in the process or industry described opposite to the disease in the second column of Schedule B, 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 6(1) of the *Act* (see policy item #26.23*, Non-Scheduled Recognition and Onus of Proof*).

Even where the requirements of the second column of Schedule B are not met, Schedule B 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 the second column of Schedule B 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.

The compensability of a claim for an ASTD listed in Schedule B where the presumption does not apply depends on whether or not the employment activities (the employment-related exposure to risk factors) played a significant role in producing the ASTD. The employment-related exposure need not be the sole or even the predominant cause; it simply needs to have been a significant cause.

EFFECTIVE DATE:	May 1, 2017
AUTHORITY:	Section 6(1) of the *Act.*
CROSS REFERENCES:	Policy item #27.00, *Activity-Related Soft Tissue Disorders ("ASTDs") of the Limbs;* Policy item #26.20, *Establishing Work Causation;* Policy item #26.23, *Non-Scheduled Recognition and Onus of Proof.*
HISTORY:	May 1, 2017 – Consequential amendment made on May 1, 2017 to reflect renumbering of policy item #26.23 (formerly #26.22). March 1, 2015 – Title changed so that it includes all ASTDs listed in Schedule B where there is no presumption. Cross reference to policy item #26.23 added because it provides general guidance on this topic. Content updated so that it applies to any ASTD where no presumption applies. June 1, 2009 – Delete references to Board officers.
APPLICATION:	Applies on or after May 1, 2017.

#27.30 ASTDs Recognized by Regulation

The following ASTDs, which may be caused or aggravated by employment activities, have been designated or recognized as occupational diseases by regulation (section 1 of the *Act*):

- Bursitis (other than the forms of bursitis mentioned in item 12 of Schedule B 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 13 of Schedule B of the *Act*), including:

- Epicondylopathy, lateral and medial;
- Stenosing Tenosynovitis (Trigger Finger); and

- Thoracic Outlet Syndrome.

For occupational diseases recognized by regulation, 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 item #26.23*, Non-Scheduled Recognition and Onus of Proof*, and policy item #27.00, *Activity-Related Soft Tissue Disorders ("ASTDs") of the Limbs*).

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. As discussed in policy items #27.31 through #27.36, 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 B presumption does not apply (see policy item #27.00, *Activity-Related Soft Tissue Disorders ("ASTDs") of the Limbs*).

EFFECTIVE DATE:	May 1, 2017
AUTHORITY:	Section 1 of the *Act.*
CROSS REFERENCES:	Policy item #26.23, *Non-Scheduled Recognition and Onus of Proof;* Policy item #27.00, *Activity-Related Soft Tissue Disorders ("ASTDs") of the Limbs;* Policy item #27.31, *Epicondylopathy;* Policy item #27.32, *Carpal Tunnel Syndrome;* Policy item #27.33, *Other Peripheral Nerve Entrapments and Stenosing Tenosynovitis;* Policy item #27.34, *Non-Specific Symptoms or Unspecified Non-Traumatic Diagnoses of the Limbs;* Policy item #27.35, *Hypothenar Hammer Syndrome;* Policy item #27.36, *Plantar Fasciitis*.
HISTORY:	May 1, 2017 – Consequential amendment made on May 1, 2017 to reflect renumbering of policy item #26.23 (formerly #26.22). December 1, 2015 – Consequential amendment resulting from creation of new policy item #27.36, *Plantar Fasciitis*, made effective December 1, 2015. March 1, 2015 – Conditions reordered alphabetically and bursitis and plantar fasciitis added to the list. Conditions listed as a subset under tendinopathy. Term epicondylopathy 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 policy items #27.31 through #27.35 should be weighed in determining whether a claim is accepted.
APPLICATION:	Applies on or after May 1, 2017.

#27.31 Epicondylopathy

Epicondylopathy is recognized as an occupational disease by regulation.

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.

EFFECTIVE DATE:	March 1, 2015
AUTHORITY:	Section 1 and 6(1) of the *Act.*
CROSS REFERENCES:	Policy item #26.23, *Non-Scheduled Recognition and Onus of Proof;* Policy item #27.00, *Activity-Related Soft Tissue Disorders ("ASTDs") of the Limbs.*
HISTORY:	Term epicondylopathy used in place of epicondylitis and definition updated based on current medical science. Minor policy changes for clarity and consistency with other ASTD policies.
APPLICATION:	This item applies to all decisions made on or after March 1, 2015.

#27.32 Carpal Tunnel Syndrome

Carpal tunnel syndrome is recognized as an occupational disease by regulation.

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.

EFFECTIVE DATE:	March 1, 2015
AUTHORITY:	Section 1 and 6(1) of the *Act.*
CROSS REFERENCES:	Policy item #26.23, *Non-Scheduled Recognition and Onus of Proof;* Policy item #27.00, *Activity-Related Soft Tissue Disorders ("ASTDs") of the Limbs.*
HISTORY:	Definition of carpal tunnel syndrome updated based on current medical science. Minor policy changes for clarity and consistency with other ASTD policies.
APPLICATION:	This item applies to all decisions made on or after March 1, 2015.

#27.33 Other Peripheral Nerve Entrapments and Stenosing Tenosynovitis

Cubital tunnel syndrome, radial tunnel syndrome, thoracic outlet syndrome, and stenosing tenosynovitis (trigger finger) are each recognized as an occupational disease by regulation.

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.

EFFECTIVE DATE:	March 1, 2015
AUTHORITY:	Section 1 and 6(1) of the *Act.*
CROSS REFERENCES:	Policy item #26.23, *Non-Scheduled Recognition and Onus of Proof;* Policy item #27.00, *Activity-Related Soft Tissue Disorders (“ASTDs”) of the Limbs.*
HISTORY:	Definitions of cubital tunnel syndrome, radial tunnel syndrome, thoracic outlet syndrome and stenosing tenosynovitis updated. Minor policy changes for clarity and consistency with other ASTD policies.
APPLICATION:	This item applies to all decisions made on or after March 1, 2015.

#27.34 Non-Specific Symptoms or Unspecified Non-Traumatic Diagnoses of the Limbs

A worker may suffer from 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 policy items #27.11 through #27.33.

The Board considers a claim of this nature on its own merits even though a clinical entity familiar to the Board has not been diagnosed. The matters referred to in policy item #26.04, *Recognition by Order Dealing with a Specific Case*, would apply to such a claim. The Board should, however, make whatever inquiries it considers appropriate in the circumstances of the claim to determine whether the worker in fact suffers from one or more of the disorders referred to in policy items #27.11 through #27.33. 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:	March 1, 2015
AUTHORITY:	Section 1 and 6(1) of the *Act.*
CROSS REFERENCES:	Policy item #26.04, *Recognition by Order Dealing with a Specific Case;* Policy item #26.23, *Non-Scheduled Recognition and Onus of Proof;* Policy item #27.00, *Activity-Related Soft Tissue Disorders ("ASTDs") of the Limbs;* Policy item #27.11, *Hand-Wrist Tendinopathy;* Policy item #27.12, *Shoulder Tendinopathy and Shoulder Bursitis;* Policy item #27.13, *Knee Bursitis;* Policy item #27.14, *Hand-Arm Vibration Syndrome;* Policy item #27.31, *Epicondylopathy;* Policy item #27.32, *Carpal Tunnel Syndrome;* Policy item #27.33, *Other Peripheral Nerve Entrapments and Stenosing Tenosynovitis.*
HISTORY:	Minor changes for clarity, including change to policy title. June 1, 2009 – Delete references to Board officers.
APPLICATION:	This item applies to all decisions made on or after March 1, 2015.

#27.35 Hypothenar Hammer Syndrome

Hypothenar hammer syndrome is recognized as an occupational disease by regulation.

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.

EFFECTIVE DATE:	March 1, 2015
AUTHORITY:	Section 1 and 6(1) of the *Act.*
CROSS REFERENCES:	Policy item #26.23, *Non-Scheduled Recognition and Onus of Proof;* Policy item #27.00, *Activity-Related Soft Tissue Disorders ("ASTDs") of the Limbs.*
HISTORY:	Policy moved to be listed after policy item #27.30, *ASTDs Recognized by Regulation*. Minor changes for clarity and consistency with the other ASTD policies.
APPLICATION:	This item applies to all decisions made on or after March 1, 2015.

#27.36 Plantar Fasciitis

"Plantar Fasciitis" is recognized as an occupational disease by regulation.

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:	December 1, 2015
AUTHORITY:	Section 1 of the *Act*.
CROSS REFERENCES:	Policy item #26.03, *Recognition by Regulation of General Application*; Policy item #27.00, *Activity-Related Soft Tissue Disorders ("ASTDs") of the Limbs;* Policy item #27.30, *ASTDs Recognized by Regulation*.
HISTORY:	New policy created by BOD Resolution No. 2015/10/22-02.
APPLICATION:	This item applies to all decisions made on or after December 1, 2015.

#28.00 CONTAGIOUS DISEASES

There are a number of contagious diseases recognized by the Board as occupational diseases either in Schedule B or by regulation. See policy item #26.03.

A worker is not entitled to compensation simply because he or she 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 suffering from 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 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 from the other, the worker who contracted tuberculosis from the shipmate may be compensated.

Example 4 — Suppose a courier develops mononucleosis and claims compensation on the ground that in the job he or she 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.

Example 5 — 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 this province are not normally exposed.

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 his or her working area of the hospital suffering from the disease, an inference may be drawn from the circumstantial evidence that the worker contacted the disease there, even though they may not remember the names of the patients, or may not remember whether they actually had 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: June 1, 2009 – Delete references to Board officer.
APPLICATION: Applies on or after June 1, 2009

#28.10 Scabies

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 be suffering from scabies is sufficient for this purpose if the worker would normally have direct contact with such persons in the performance of his or her 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, there is likely to be insufficient positive evidence to conclude that the worker suffers from scabies which is due to the nature of his or her employment.

#29.00 RESPIRATORY DISEASES

#29.10 Acute Respiratory Reactions to Substances with Irritating or Inflammatory Properties

Schedule B 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 listed opposite to it is "Where there is exposure to a high concentration of fumes, vapours, gases, mists, or dust of substances that have irritating or inflammatory properties, and the respiratory symptoms occur within 48 hours of the exposure, or within 72 hours where there is exposure to nitrogen dioxide or phosgene".

There are many agents used in industry and commerce in the province which 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 6(3) 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 B). 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 6(3) of the *Act* are not met (see policy item #26.23). 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.

Use of the words “high concentration” in Schedule B 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.

EFFECTIVE DATE:	May 1, 2017
HISTORY:	May 1, 2017 – Consequential amendment made on May 1, 2017 to reflect renumbering of policy item #26.23 (formerly #26.22).
APPLICATION:	Applies on or after May 1, 2017.

#29.20 Asthma

Schedule B lists “Asthma” as an occupational disease. The process or industry listed opposite to it is “Where there is exposure to

(1) western red cedar dust; or

(2) isocyanate vapours or gases; or

(3) the dusts, fumes or vapours of other chemicals or organic material known to cause asthma.”

1. 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 occupational and non-occupational 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 occupational and non-occupational 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.

2. Pre-existing Asthma Condition

A pre-existing asthma condition is not compensable unless such underlying condition has been significantly aggravated, activated, or accelerated by an occupational exposure. A worker is not entitled to compensation where his or her 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 a significant cause of an 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 insufficient for the acceptance of a claim.

3. Temporary Disability

In the case of a compensable asthma or a respiratory tract reaction to a substance with irritating or inflammatory properties, temporary disability benefits are payable until 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 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 he or she is left with a permanent impairment of the respiratory system, the Board may grant a permanent disability award after considering the asthma tables in the *Permanent Disability Evaluation Schedule*.

(ii) 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 his or her pre-exposure state, the Board may grant a permanent disability award after considering the asthma tables in the *Permanent Disability Evaluation Schedule*. In these cases, the Board considers whether proportionate entitlement under section 5(5) of the *Act* is appropriate. (See policy items #44.00 to #44.31.)

In the situation described above, no permanent disability award is granted to a worker with a pre-existing asthma condition when the worker has returned to his or her pre-exposure state.

(iii) 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.

EFFECTIVE DATE:	March 1, 2018
HISTORY:	March 1, 2018 – Consequential amendment resulting from correcting typographical error in Schedule B. January 1, 2007 – Policy 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 to update terminology.
APPLICATION:	To claims where the worker is first disabled from earning full wages, in accordance with section 6(1) of the *Workers Compensation Act*, on or after March 1, 2018.

#29.30 Bronchitis and Emphysema

Bronchitis and emphysema are recognized as occupational diseases by regulation under section 1 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. (7)

#29.40 Pneumoconioses and Other Specified Diseases of the Lungs

The guiding legislation in compensation for pneumoconioses is provided in sections 6(3) and 6(7) through 6(11) of the *Act*. Pneumoconiosis is a general medical term used to describe certain lung diseases due to deposition of particulate matter in the lungs.

#29.41 Silicosis

Schedule B lists "Silicosis" as an occupational disease. The process or industry described opposite to it is "Where there is exposure to airborne silica dust including metalliferous mining and coal mining". This later 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 6(8) 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. Where death results from the disability, the dependants of the worker are entitled to compensation. However, neither a worker nor a dependant is entitled to compensation for the disability or death unless the worker:

(a) has been a resident of the province for a period of at least three years last preceding his or her disablement, or unless at least two-thirds of their exposure to dust containing silica was in this province; and

(b) was free from silicosis and tuberculosis before being first exposed to dust containing silica in the metalliferous mining or coal mining industry in this province; and

(c) has been a worker exposed to dust containing silica in the metalliferous mining or coal mining industry in the province for a period or periods aggregating three years preceding his or her disablement, or for a lesser period if the worker was not exposed to dust containing silica anywhere except in this province.

"Silicosis" is defined in section 6(7) as ". . . a fibrotic condition of the lungs caused by the inhalation of silica dust". "Metalliferous mining industry" is defined in section 1 to include "the operations of milling and concentrating, but does not include any other operation for the reduction of minerals".

#29.42 Meaning of Disabled from Silicosis

The restrictions contained in section 6(1) 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 he or she was employed.

It is a requirement in a claim 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 the permanent disability award 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 award on the previous earnings thus discovered.

EFFECTIVE DATE: June 1, 2009 – Delete references to Board officers.
APPLICATION: Applies on or after June 1, 2009.

#29.43 Exposure to Silica Dust Occurring Outside the Province

Where the three criteria set out in policy item #29.41 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. The Board will therefore pay full compensation to the worker without regard to the extent of exposure to silica dust outside the province. (8)

#29.45 Pneumoconiosis

When a worker has sustained pulmonary injury by a disabling form of pneumoconiosis as a result of exposure to dust conditions that are deemed by the Board to have contributed to the development of the disease in employment in the province in an industry in which that disease is an occupational disease under the *Act*, such worker or their dependants is or are entitled to compensation only if the worker was free from pneumoconiosis and tuberculosis before being first exposed to those dust conditions in the province, and if the worker's residence and exposure to the dust conditions have been of the duration required to entitle a worker to compensation for silicosis under policy item #29.41. (9)

Schedule B lists "Other pneumoconioses" as an occupational disease. The process or industry described 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".

#29.46 Asbestosis

Schedule B lists "Asbestosis" as an occupational disease. The process or industry described 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.

#29.47 Diffuse Pleural Thickening or Fibrosis and Benign Pleura Effusion

Schedule B lists "Diffuse pleural thickening or fibrosis, whether unilateral or bilateral" as an occupational disease. The process or industry described opposite to it is "Where there is exposure to airborne asbestos dust and the claimant has not previously suffered and is not currently suffering collagen disease, chronic uremia, drug-induced fibrosis, tuberculosis or other infection, trauma, or disease capable of causing pleural thickening or fibrosis."

Schedule B also lists "Benign pleural effusion, whether unilateral or bilateral" as an occupational disease. The process or industry described opposite to it is "Where there is exposure to airborne asbestos dust and the claimant has not previously suffered and is not currently suffering collagen disease, chronic uremia, tuberculosis or other infection, trauma, or disease capable of causing pleural effusion."

These items in Schedule B 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.

#29.48 Mesothelioma

Schedule B lists "Mesothelioma (pleural or peritoneal)" as an occupational disease. The process or industry described 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.

#29.50 Presumption Where Death Results from Ailment or Impairment of Lungs or Heart

Section 6(11) provides that:

> Where a deceased worker was, at the date of his death, under the age of 70 years and suffering from an occupational disease of a type that impairs the capacity of function of the lungs, and where the death was caused by

> some ailment or impairment of the lungs or heart of non-traumatic origin, it must be conclusively presumed that the death resulted from the occupational disease.

This provision does not apply to deaths occurring before July 1, 1974.

The question whether the deceased suffered from 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'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 his or her 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 6(11) 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 over 70 years of age 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.

#30.00 CANCERS

Mesothelioma is covered in policy item #29.48.

#30.10 Bladder Cancer

Schedule B lists "Primary cancer of the epithelial lining of the urinary bladder, ureter or renal pelvis" as an occupational disease. The process or industry described 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 4(h) of Schedule B.

In addition to the chemicals listed in Schedule B, 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 Schedule B 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 his/her 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.

EFFECTIVE DATE: June 1, 2009 – Delete references to Board officers.
APPLICATION: Applies on or after June 1, 2009.

#30.20 Gastro-intestinal Cancer

Schedule B lists "Gastro-intestinal cancer (including all primary cancers associated with the oesophagus, stomach, small bowel, colon and rectum excluding the anus, and without regard to the site of the cancer in the gastro-intestinal tract or the histological structure of the cancer)" as an occupational disease. The process or industry described opposite to Gastro-intestinal cancer is "Where there is exposure to asbestos dust if during the period between the first exposure to asbestos dust and the diagnosis of gastro-intestinal 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 it occurred."

Gastro-intestinal cancer suffered by a worker who has not been exposed to asbestos fibres in the course of their employment, or whose exposure to such fibres does not substantially have the duration, continuity and extent described in the second column of Schedule B, will not normally be considered to be due to employment.

Where there has been less than 20 years of continuous exposure to asbestos fibres, such that the presumption in section 6(3) does not apply, but there has been substantial compliance with the requirements of the second column of Schedule B, the Board will consider whether the evidence indicates that the gastro-intestinal cancer is due to the nature of the worker's employment. 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. (10)

EFFECTIVE DATE: June 1, 2009 – Delete references to Board officers.
APPLICATION: Applies on or after June 1, 2009.

#30.50 Contact Dermatitis

Schedule B lists "Contact dermatitis" as an occupational disease. The process or industry described 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 such underlying condition has been significantly aggravated, activated, or accelerated by an occupational exposure. A worker is not entitled to compensation where his or her 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 a significant cause of an 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 insufficient for the acceptance of a claim.

3. Temporary Disability

Temporary disability 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

Where 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 he or she is left with a permanent impairment of the skin, the Board may grant a permanent disability award after considering the contact dermatitis table in the *Permanent Disability Evaluation Schedule*.

(ii) Permanent Aggravation of Pre-existing Dermatitis

Where workplace exposures have caused a permanent aggravation of the worker's pre-existing dermatitis condition, so that the worker is unlikely to return to his or her pre-exposure state, the Board may grant a permanent disability award after considering the contact dermatitis table in the *Permanent Disability Evaluation Schedule*. In these cases, the Board considers whether proportionate entitlement under section 5(5) of the *Act* is appropriate. (See policy items #44.00 to #44.31.)

In the situation described above, no permanent disability award is granted to a worker with a pre-existing condition when the worker has returned to his or her pre-exposure state.

(iii) Contact Dermatitis due to Sensitization

Where 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 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 recurrent signs and symptoms of marked extent and severity when exposed to a workplace sensitizing agent. The worker experiences these signs and symptoms when he or she 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.

EFFECTIVE DATE:	January 1, 2007
APPLICATION:	To claims where the worker is first disabled from earning full wages, in accordance with section 6(1) of the *Workers Compensation Act*, on or after January 1, 2007.

#30.70 Heart Conditions

Heart-related conditions which arise out of and in the course of a person'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 6 of the *Act*. (See Item C3-16.00, *Pre-Existing Conditions or Diseases*).

EFFECTIVE DATE: May 29, 2014
APPLICATION: Applies to all decisions made on or after May 29, 2014.

#31.00 HEARING LOSS

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 5(1) and, if a permanent disability results, a permanent disability award is granted in accordance with the scale provided for in the Permanent Disability Evaluation Schedule (for hearing loss that is secondary to an injury see Item C3-22.00, *Compensable Consequences*).

(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. However, the provisions of section 6 do not apply unless the worker ceased to be exposed to causes of hearing loss prior to September 1, 1975. In all other cases, section 7 of the *Act* applies. If the provisions of section 6 of the *Act* apply to the claim, the worker may be entitled to the payment of health care 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 policy item #26.30, *Disabled from Earning Full Wages at Work*).

Section 7(1) provides that "Where a worker suffers loss of hearing of non-traumatic origin, but arising out of and in the course of employment . . ., that is a greater loss than the minimum set out in Schedule D, the worker is entitled to compensation . . ." Schedule D is set out in policy item #31.40, *Amount of Compensation under Section 7*.

Schedule B 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 7 of the *Act* which requires that the loss of hearing 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 D. 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 resulting portion of the worker's total impairment is then assessed for an award using the percentage ranges listed in Schedule D.

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, *Compensable Consequences*); 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 23(1) 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

EFFECTIVE DATE: June 1, 2012
APPLICATION: Applies to all decisions made on or after June 1, 2012.

#31.10 Date of Commencement of Section 7

Section 7(5) of the *Act* provides as follows:

> Compensation under this section is not payable in respect of a period prior to September 1, 1975; but future compensation under this section is payable in respect of loss of hearing sustained by exposure to causes of hearing loss in the Province either before or after that date, unless the exposure to causes of hearing loss terminated prior to that date.

Section 7 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 "terminated" as used in section 7(5) means the end once and for all of a course of exposure to causes of hearing loss. Exposure is not terminated 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 "termination". Subsequent exposure for any period of time in bona fide employment allows for consideration of compensation under section 7.

Only exposure to noise in industries under Part 1 of the *Act* after September 1, 1975 should be considered to determine whether or not a worker qualifies for compensation under section 7.

If a worker's exposure to causes of hearing loss terminated prior to September 1, 1975, no compensation is payable under section 7 whatever may be the reasons for this termination. No exception can be made if, for instance, the termination came about because a previous compensable injury forced the worker to leave his or her employment. A worker whose exposure ceased prior to September 1, 1975 may be entitled to health care (hearing aids) under section 6 of the *Act*.

#31.20 Amount and Duration of Noise Exposure Required by Section 7

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 when other evidence does not disclose any cause of hearing loss not related to work. The Board considers it reasonable to set the 85 dBA minimum standard for compensation purposes and then to allow a restricted measure of discretion for the acceptance of claims where the evidence is abundantly clear 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 soundproof booths, where evidence shows that the booth was used regularly, was sealed 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 costs related to the total hearing loss including the provision of hearing aids.

It has been suggested that after 10 years of exposure further loss is negligible. Generally speaking, the evidence is that the first 10 years has a significant effect at higher frequencies. However, where lower frequencies are concerned (up to 2,000 hz.) hearing loss continues after that time and may, in fact, accelerate in those later years. Therefore, since the disability assessment under Schedule D relies on frequencies of 500, 1,000 and 2,000 hz., no adjustments for duration of exposure are made.

EFFECTIVE DATE:	December 1, 2004 – regarding clarification of jurisdictional requirements and minor amendments.
APPLICATION:	Applies to all decisions made on or after December 1, 2004.

#31.30 Application for Compensation under Section 7

Section 7(6) 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 loss of hearing that the Board prescribes”.

Where a worker has already applied for compensation for hearing loss under section 6, a separate application under section 7 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.

EFFECTIVE DATE:	March 3, 2003 (as to deletion of references to appeal reconsideration)
APPLICATION:	Not applicable.

#31.40 Amount of Compensation under Section 7

No temporary disability payments are made to workers suffering from non-traumatic hearing loss.

Workers who develop non-traumatic noise induced hearing loss are, subject to the time periods referred to in section 23.1 of the *Act*, assessed for a permanent disability award under section 23 of the *Act*.

Hearing loss permanent disability awards are determined on the basis of audiometric tests conducted at the Audiology Unit of the Board 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 7(3.1) of the *Act* provides:

> The Board may make regulations to amend Schedule D in respect of
>
> (a) the ranges of hearing loss,
>
> (b) the percentages of disability, and
>
> (c) the methods or frequencies to be used to measure hearing loss.

Where the loss of hearing amounts to total deafness measured in the manner set out in Schedule D, but with no loss of earnings resulting from the loss of hearing, section 7(2) provides that compensation shall be calculated as for a disability equivalent to 15% of total disability. Where the loss of hearing does not amount to total deafness, and there is no loss of earnings resulting from the loss of hearing, section 7(3) provides that compensation shall be calculated as for a lesser percentage of total disability, and, unless otherwise ordered by the Board, shall be based on the percentages set out in Schedule D. Schedule D is set out below.

SCHEDULE D

Non-Traumatic Hearing Loss

Complete loss of hearing in both ears equals 15% of total disability. Complete loss of hearing in one ear with no loss in the other equals 3% of total disability.

	Percentage of Total Disability	
Loss of Hearing in Decibels Measured in Each Ear in Turn	**Ear Most Affected PLUS Ear Least Affected**	
0-27	0	0
28-32	0.3	1.2
33-37	0.5	2.0
38-42	0.7	2.8
43-47	1.0	4.0
48-52	1.3	5.2
53-57	1.7	6.8
58-62	2.1	8.4
63-67	2.6	10.4
68 or more	3.0	12.0

The loss of hearing in decibels in the first column is the arithmetic average of thresholds of hearing measured in each ear in turn by pure tone, air conduction audiometry at frequencies of 500, 1000 and 2000 Hertzian waves, the measurements being made with an audiometer calibrated according to standards prescribed by the Board.

In assessing permanent disability awards under section 7, there is no automatic allowance for presbycusis. In some cases, however, the existence of presbycusis may be relevant in deciding whether the worker has suffered a hearing loss due to their employment. The age adaptability factor is not applied to awards made under section 7.

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 loss of hearing, and where this non-occupational component cannot be accurately measured using audiometric tests, then "Robinson's Tables" will apply. "Robinson's Tables" will only be applied where there is some positive evidence of non-occupational causes or components in the worker's loss of hearing (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.

"Robinson's Tables" were statistically formulated to calculate the expected hearing loss following a given exposure to noise. In applying these tables, the

cumulative period of noise exposure is calculated. A factor for aging is then added. For permanent disability award purposes, the resulting calculation is then compared on "Robinson's Tables" to the worst 10% of the population (i.e., at the same levels and extent of noise exposure, 90% of individuals will have better hearing than the worker).

In some cases, it will be found that a worker has already suffered a 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 D (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 their disability commenced. If there are no current earnings on which to base the permanent disability award, the Board should generally refer back to the employments in which the worker was most recently engaged and base the award on their previous earnings thus discovered.

If the worker is retired and under the age of 63 years as of the commencement of the hearing loss permanent disability award, 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 hearing loss permanent disability award, periodic payments are made for two years following such date. See policy item #41.00, Duration of Permanent Disability Periodic Payments.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officers.
HISTORY:	August 1, 2003 – Disability rating changed for complete loss of hearing in one ear with no loss in the other. Revision also made to the frequencies at which loss of hearing is to be measured.
APPLICATION:	Applies on or after June 1, 2009.

#31.50 Compensation under Section 7

Section 7(4) provides:

> If a loss or reduction in earnings results from the loss of hearing, the worker is entitled to compensation for total or partial disability as established under this Part.

Section 7(4.1) also provides:

> Compensation paid for a worker's loss of hearing under subsection (4) must not be less than the amount determined under subsection (2) or (3).

Compensation 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 any form. In other words, compensation is payable for a disability that has been incurred, not for the prevention of one that might occur.

Where a noise-induced hearing loss has been incurred, if 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. Compensation in such cases is, as in all other cases, based on section 23(1) method of permanent disability assessment. The drop in earnings may be the triggering device that renders the worker eligible for compensation, but it is not part of the formula for calculating the amount.

The duration of entitlement to permanent disability periodic payments is established under section 23.1 of the *Act* and discussed in policy item #41.00, Duration of Permanent Disability Periodic Payments.

#31.60 Reopenings of Section 7 Pension Decisions

Where the loss of hearing of a worker who is in receipt of a permanent disability award under section 7 is retested on or after June 30, 2002 and there is a significant change in the worker's hearing, the following applies:

1. Where the retest records a deterioration in the worker's hearing and the new findings warrant an increase under Schedule D of the *Act*, the permanent disability award decision is reopened and the award is increased.

2. If the retest shows an improvement in the worker's hearing of a degree greater than 10 decibels, the worker's award is reopened. Where this occurs, two further considerations would apply.

    (a) Where the worker has been paid the award in the form of a lump-sum payment, the worker is advised in writing that his or her 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) Where the worker's award is being paid in the form of a periodic monthly 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 award was set, but the improvement is within a range up to and including 10 decibels, the permanent disability award is not reopened.

A worker who has ceased to have entitlement to a permanent disability award in accordance with the provisions of section 23.1 of the *Act* (see policy item #41.00) will not be retested by the Board.

EFFECTIVE DATE: March 3, 2003 (as to references to reopening, review and the Review Division).
APPLICATION: Not applicable.

#31.70 Compensation for Non-Traumatic Hearing Loss under Section 6

A worker will only be entitled to compensation for non-traumatic hearing loss under section 6(1) if their exposure to causes of hearing loss terminated prior to September 1, 1975. "Neurosensory hearing loss" is one of the occupational diseases listed in Schedule B of the *Act.* The process or industry described opposite to it is "Where there is prolonged exposure to excessive noise levels".

Section 55 of the *Act* sets out the time limits within which an application for compensation must be filed. Subsection (4) of the present section 55 provides:

> This section applies to an injury or death occurring on or after January 1, 1974 and to an occupational disease in respect of which exposure to the cause of the occupational disease in the Province did not terminate prior to that date.

The result of this provision is that where a worker's exposure to causes of hearing loss terminated prior to January 1, 1974, the present section 55 does not apply and one must look to the provision which was repealed on the enactment of this section.

Under the previous section 55 (then numbered 52), a claim is, subject to subsection (4), barred unless an application for compensation, or in the case of health care, proof of disablement, is filed within one year after the day upon which disablement by industrial disease occurred. The Board has no general power to waive these requirements and extend the time period in which an application must be submitted beyond the period set out in section 52(4). To determine what is meant by "disablement" in this provision, one must refer back to section 6(1) of the *Act* which provides in part that no compensation, other than health care, is payable in respect of an occupational disease unless the worker is ". . . thereby disabled from earning full wages at the work at which the worker was employed . . ." The one-year time period under the previous and current section 55 does not begin to run until the worker becomes disabled from earning full wages within the meaning of section 6(1). It follows that in cases where the exposure to causes of hearing loss terminated prior to

January 1, 1974, and no disablement within the meaning of section 6(1) has yet occurred, health care 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 their exposure terminated. Once the disablement from earning full wages occurs, the worker then has one year to submit an application for compensation (if they have 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 they 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.

#31.80 Commencement of Permanent Disability Periodic Payments under Sections 6 and 7

The following applies to claims for loss of hearing of non-traumatic origin.

1. Where compensation is being awarded under section 6, then, subject to section 55, permanent disability awards shall be calculated to commence as of the date upon which the worker first became disabled from earning full wages at the work at which the worker was employed.

2. Where compensation is being awarded under section 7 in respect of a loss of earnings or impairment of earnings capacity, then, subject to section 55, permanent disability awards shall be calculated to commence as of the date when the worker first suffered such loss of earnings or impairment of earnings capacity, or as of September 1, 1975, whichever is the later.

3. Where compensation is being awarded under section 7 but not in respect of any loss of earnings or impairment of earning capacity, then, subject to section 55, permanent disability awards 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 D of the *Act*. Where 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. In no case will award benefits under section 7(3) commence prior to September 1, 1975.

#32.00 OTHER MATTERS

#32.10 Psychological/Emotional Conditions

The Board does accept claims where the psychological condition is a consequence of a compensable personal injury or occupational disease. (14) However, the Board has not recognized any psychological or emotional conditions as occupational diseases related to employment.

#32.15 Alcoholism

Alcoholism and alcohol-related cirrhosis of the liver have not been recognized by the Board as occupational diseases. (15)

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 alcoholic's individual physiology and psychology, their family, social and cultural surroundings and their own personal inability to control consumption.

#32.50 "Date of Injury" For Occupational Disease

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

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

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officer.
HISTORY:	October 1, 2007 – Revised to delete reference to assigning a claim number.
APPLICATION:	Applies on or after June 1, 2009.

#32.55 Time Limits and Delays in Applying for Compensation

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

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

> (2) Unless an application is filed, or an adjudication made, within one year after the date of . . . death or disablement from occupational disease, no compensation is payable, except as provided in subsections (3), (3.1), (3.2), and (3.3).

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

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

#32.56 Applicants Who File Within Three Years

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

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

Section 55(3) says:

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

For a discussion of special circumstances, see policy item #93.22.

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

#32.57 Applicants Who File Beyond Three Years

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

Section 55(3.1) says:

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

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

#32.58 Newly Recognized Occupational Diseases

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

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

1. At the time of the worker's death or disablement, the Board does not have sufficient medical or scientific evidence to recognize the disease as an occupational disease for this worker's kind of employment (even though the Board may have recognized it as an occupational disease for other kinds of employment).

2. The Board subsequently obtains sufficient medical or scientific evidence to cause it to recognize the disease as an occupational disease for this worker's kind of employment.

3. The application for compensation is made within three years after the date the Board recognized the disease as an occupational disease for this worker's kind of employment.

Section 55(3.2) says:

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

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

(b) sufficient medical or scientific evidence was not available on the date referred to in subsection (2) for the Board to recognize the disease as an occupational disease and this evidence became available on a later date, and

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

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

Section 55(3.3) says:

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

For example, in the 1970s sufficient medical or scientific evidence was not available for the Board to recognize an association between exposure to coal tar pitch volatiles in aluminum smelters and an excess risk of bladder cancer. It was not until the late 1980s that sufficient evidence became available for the Board to recognize such an association. (However, the Board had earlier recognized that there was an association between bladder cancer and prolonged exposure to certain chemicals used primarily in the manufacture of rubber and dyes. In 1980 "primary cancer of the epithelial lining of the urinary bladder" was added to Schedule B, with a corresponding presumption in favour of causation where the worker had prolonged exposure to any of three listed chemicals.)

On March 13, 1989, the Board issued a policy directive recognizing bladder cancer as an occupational disease for workers employed in aluminum smelting, dependent on the concentration and length of exposure to coal tar pitch volatiles.

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

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

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

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

#32.59 Discretion to Pay Compensation

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

The Board considers the availability of evidence, such as:

- medical records about the worker's state of health at relevant times (cause of death in the case of a deceased worker)

- employment records that may document exposures to contaminants or hazardous processes, or periods of disability that may have been due to the occupational disease

- evidence from co-workers or others who may know about the worker's employment activities.

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

- the worker's disease was causally connected to the employment, or

- the worker was disabled by the disease when claimed.

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

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

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

#32.80 Federal Government Employees

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. Section 4(4) of this *Act* applies a similar provision to railway employees of the Federal Government.

The meaning of "employee" is discussed in policy item #8.10, *Federal Government Employees*. The place where an employee is usually employed is discussed in Item C3-12.10, *Federal Government Employees*.

#32.85 Meaning of "Industrial Disease" under Government Employees Compensation Act

"Industrial Disease" is defined in section 2 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 dependents of deceased workmen".

Any employee who is disabled by reason of any 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 (17) 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.

NOTES

~~(1) Decision No. 231, 3 W.C.R. 87~~**DELETED**

(2) Decision No. 3, 1 W.C.R. 11

(3) S.6(1)(a)

(4) Decision No. 99, 2 W.C.R. 15

(5) Decision No. 205, 3 W.C.R. 16

~~(6) ODSC Charter, I W.C.R. 135~~ **DELETED**

(7) Decision No. 207, 3 W.C.R. 21

(8) An agreement entered into pursuant to section 8.1 of the *Act* may supersede

(9) S.6(10)

(10) Decision No. 232, 3 W.C.R. 91

~~(11) Decision No. 267, 3 W.C.R. 188~~ **DELETED**

~~(12) See policy item #93.24~~ **DELETED**

~~(13) See Chapter 6~~ **DELETED**

(14) See Items C3-12.00, *Personal Injury*, C3-22.30, *Compensable Consequences – Psychological Impairment* and C3-22.40, *Compensable Consequences – Certain Diseases and Conditions*

(15) Decision No. 348, 5 W.C.R. 127

~~(16) Decision No. 102, 2 W.C.R. 25~~ **DELETED**

(17) *Government Employees Compensation Act*, S.8(1)(a)

CHAPTER 5

WAGE-LOSS BENEFITS

#33.00 INTRODUCTION

Wage-loss benefits are payable where an injury or disease resulting from a person's employment causes a period of temporary disability from work. These benefits usually commence shortly after the initial acceptance of a claim and may be total (section 29) or partial (section 30). They cease when the worker recovers from the injury or the condition becomes a permanent one. In the latter event, the worker is entitled to be assessed for a permanent partial disability award. This entitlement is dealt with in Chapter 6.

Wage-loss benefits are calculated on the basis of a worker's "average net earnings". The computation of average net earnings is dealt with in Chapter 9.

#34.00 TEMPORARY TOTAL DISABILITY PAYMENTS

Where a temporary total disability results from an injury, section 29(1) provides that the compensation consists of periodic payments to the injured worker equal in amount to 90% of her or his average net earnings.

#34.10 Meaning of Temporary Total

It is obvious that for every claim there must be physical impairment as the result of a work-related injury or occupational disease. It is the instigating factor without which the system never comes into play. Once it is found that a worker has suffered such an impairment it becomes necessary to determine the extent of compensation payable, i.e. the consequences of the impairment. 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 22, 23, 29 and 30 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 medical impairment, benefits to compensate for the consequences of that impairment shall be paid in accordance with the requirements of the appropriate section of the *Act*.

It follows from the above that in order to be eligible for benefits under section 29(1) a worker must have a temporary total physical impairment as a result of the injury.

A “temporary” physical impairment is one which is likely to improve or become worse and is therefore not stable. Realistically speaking, ongoing change is a natural feature of human physiology. Impairments resulting from an injury commonly deteriorate or improve over a period of years. 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 only remains temporary when such a change can reasonably be foreseen in the immediate future. (1)

Most compensable injuries and diseases involve an initial period of temporary disability during which wage-loss benefits are paid. This disability will usually improve in time until it disappears entirely or becomes 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 is 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 a permanent partial disability award.

Even if a worker is found to have a temporary total physical impairment, no wage-loss payments will be made unless that impairment in fact causes the cessation of regular employment. If the impairment causes only a partial cessation from this work or some alternative light work is taken up, benefits are calculated under section 30.

References to “physical impairment” in the above paragraphs include “psychological impairment” where the worker’s disability is psychological in nature.

#34.11 Selective/Light Employment

STATEMENT OF PRINCIPLE

Selective/light employment is a temporary work alternative, offered by an employer, that is intended to promote a worker’s gradual restoration to the pre-injury level of employment. The arrangement may involve duties different from the pre-injury employment, or some modification of the pre-injury duties and/or hours of work. Selective/light employment arrangements may involve consultation with the worker, employer, the worker’s attending physician or other medical practitioners and the union.

Selective/light employment is typically offered at or soon after the date of injury, generally prior to the Board’s involvement on the claim. Selective/light employment differs from graduated return to work programs which are normally initiated after the worker has participated in some form of medical treatment or rehabilitation program.

The Board supports selective/light employment as an important component of a worker's rehabilitation and recognizes the value of maintaining an injured worker's positive connection to the workplace. It has been amply demonstrated that the earlier a worker is able to safely return to productive employment following an injury, the more likely he or she is of obtaining maximum recovery.

CRITERIA

To ensure that the early return-to-work is appropriate, all selective/light employment arrangements must meet the following conditions:

- While the compensable injury may temporarily disable the worker from performing his or her normal work, the worker must be capable of undertaking some form of suitable employment.
- The work must be safe, that is, it will neither harm the worker nor slow recovery. The work must be within the worker's medical restrictions, physical limitations and abilities. Where there is a disagreement regarding the safety of the selective/light offer and the Board is required to intervene, the Board is responsible for determining the safety of the work after considering the medical evidence and other relevant information.
- The work must be productive. Token or demeaning tasks are considered detrimental to the worker's rehabilitation.
- Within reasonable limits, the worker must agree to the arrangement.

INTERVENTION

The Board recognizes that the successful development of selective/light employment opportunities depends on the cooperation of all parties in the workplace. In the following situations, the Board will intervene to determine if a particular offer of selective/light employment is suitable:

- The worker and/or the worker's attending physician disagree with the employer's position that the work is safe.
- The worker and employer are in disagreement over the terms of the return-to-work.
- There is a request for intervention by either the worker or employer.
- The Board considers that further inquiry is required.

ADJUDICATION

On intervention, the Board's evaluation will be based on, but not limited to, a detailed description of the employment being offered, including the physical requirements and detailed medical information outlining the worker's medical restrictions, physical limitations and abilities.

Where a worker refuses to accept the offer, the Board will consider the reasons for refusal and determine if they are reasonable. In making this determination, the Board will give regard to the requirements of the work, medical opinion(s) and other evidence regarding the worker's medical restrictions, physical limitations and abilities. Notwithstanding, the Board has discretion to consider additional factors or evidence relevant to the case, such as transportation (see Item C10-83.00) and child-care (see Item C10-83.10).

Should the Board determine that the worker's refusal is unreasonable, benefit entitlement is determined under section 30 of the *Act*. For example, the worker does not provide the selective/light duties to the attending physician or the worker refuses to return to work after the physician has determined the duties are suitable. Benefit entitlement will be adjusted effective the date the selective/light employment was suitable and available, as determined by the Board.

Where a worker accepts suitable selective/light employment, benefit entitlement will be determined under section 30 of the *Act*. Benefit entitlement will be adjusted effective the date the selective/light employment was suitable and available, as determined by the Board.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officers.
HISTORY:	Consequential amendments arising from changes to Chapter 10, *Medical Assistance, Rehabilitation Services and Claims Manual*, were made effective January 1, 2015. January 1, 2005 – Amendments apply to all injuries on or after January 1, 2005 and include adding a definition of selective/light employment; confirming the Board officer's responsibility for determining whether the selective/light offer is safe for the worker from a review of the medical evidence; and adding a date of when to adjust benefits when it is determined that an employer's selective/light offer is suitable and the worker unreasonably refused to return to work.
APPLICATION:	Applies on or after June 1, 2009

#34.12 Worker in Receipt of Permanent Disability Award

Wage-loss benefits are terminated when the worker's condition becomes permanent and prior to the assessment of any permanent disability award. However, they may again become payable because a further work injury or a natural relapse in the condition for which the permanent disability award is being paid causes a further period of temporary disability.

With regard to the latter situation, it is recognized that no condition is ever absolutely stable or permanent; there will commonly be some degree of fluctuation. Nevertheless, a permanent disability award 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 a permanent disability award 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 causing the disability are within the range normally to be expected from the condition for which the worker has been granted a permanent disability award, no wage loss is payable. The permanent disability award is intended to cover such fluctuations. Wage loss is 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 worker's permanent disability award will simply be reassessed.

#34.20 Minimum Amount of Compensation

Wage-loss compensation cannot be less per week than the minimum set out below, unless the worker's average earnings are less than that sum per week, in which case compensation is paid in an amount equal to average earnings. (2)

			$ Per Week
January 1, 2018	—	December 31, 2018	405.87
January 1, 2019	—	December 31, 2019	415.79

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

The minimum is subject to cost of living adjustments as described in policy item #51.20. However, these adjustments only apply to injuries or disablements occurring after they 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.

#34.30 Commencement of Payment

Section 5(2) provides that "Where an injury disables a worker from earning full wages at the work at which the worker was employed, compensation is payable. . . from the first working day following the day of the injury; but a health care benefit only is payable . . . in respect of the day of the injury."

While the plain wording of the section would seem clearly to indicate that "day of the injury" means calendar day, the Board finds that the intention of the legislation is not to provide payment for the "shift" on which the worker is injured but to provide payment for any subsequent "shift" on which the worker is

disabled. Payment of compensation, therefore, will commence effective the shift next following the shift on which the worker is injured.

#34.31 Worker Continues to Work After Injury

If a worker continues to work beyond the day of the injury, no compensation is payable until it actually causes a lay-off from work. If the worker works or is paid for part of the day on which the lay-off occurs, the amount of compensation paid for that day is as follows:

(a) if he or she works or is paid for one quarter of the day or less, compensation is paid for the full day;

(b) if he or she works or is paid for more than one quarter but less than three quarters of the day, compensation is paid for half the day;

(c) if he or she works or is paid for three quarters of the day or more, compensation is not paid for the day.

Except where section 34(1) is being applied, (3) the employer is not refunded any money paid to the worker for time not worked on the day when he or she lays off work.

The above rules apply equally where the worker becomes disabled from working following a recurrence of a compensable condition.

#34.32 Strike or Other Lay-Off on Day Following Injury

In cases where a worker's job would not have been available during a period of disability, or for some reason the worker cannot or will not be returning to the prior job upon recovery, the following general guidelines will apply.

1. Where the injury disables the worker beyond the day of the injury and this results in an actual loss of earnings or a potential loss of earnings, the requirement of section 5(2) will be met and wage-loss compensation will be paid.

2. Where the disability beyond the day of injury does not result in any actual or potential loss of earnings, the requirements of section 5(2) will be deemed to have not been met.

In interpreting "potential loss" no rigid rules can be established since every case will have to be determined on the information received. In situations where there is a lay-off due to lack of work, a worker would normally be considered as having suffered a potential loss. The position would be similar where a partially disabled worker has continued work on light work and has been laid off due to a lack of work, but payments on such a claim would be considered under section 30 of the

Act. The general expectation in those situations is that the worker would, if not injured, have immediately sought new employment and the Board should not speculate as to if and when it would have been found. If, however, there is evidence to rebut this general expectation, the Board may conclude in a particular situation that there was no actual or potential loss. For example, suppose a homemaker has been injured in the course of a single day's work at a polling station during an election and has no other attachment to the labour force whatsoever. The homemaker would not normally be available on the general labour market beyond the one day of work at the polling station.

There are other situations where, immediately following the lay-off, it would not normally be expected that the worker would seek other work, for example, strikes, a statutory holiday, weekends or normal days off, vacations or absences required for medical treatment unrelated to the work injury. It will normally be considered that there is no loss or potential loss in such cases. Again, however, the opposite conclusion may be reached if there is evidence that the worker would have undertaken other work but the injury prevented it.

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 temporary disability benefits, it does not normally discontinue them simply because, irrespective of the injury, the worker would not have been working for some period of time. This applies even in cases where the worker recovers from the initial disability and benefits are terminated but the worker subsequently suffers a recurrence within three years of the compensable condition. The fact that the worker is, for example, on strike at the time of the recurrence does not bar the payment of benefits for temporary total disability.

See policy item #35.30 for policy on the duration of temporary disability benefits.

#34.40 Pay Employer Claims

Section 34(1) provides that "In fixing the amount of a periodic payment of compensation, consideration must be had to payments, allowances or benefits which the worker may receive from the worker's employer during the period of the disability, including a pension, gratuity or other allowance provided wholly at the expense of the employer, and a sum deducted under this section from the compensation otherwise payable may be paid to the employer . . ."

The section does not provide that any payment made by the employer shall be deducted from the compensation, or that any compensation deducted shall be paid to the employer. It requires that the Board must consider the matter, and that any compensation deducted under this section may be paid to the employer. The section is permissive, not mandatory, and the question is, therefore, in what circumstances a deduction should be made.

In practice, employers who continue paying full wages to disabled workers are reimbursed in amounts equal to the compensation that would normally be paid to their employees. No refund is made for the difference between the amount of compensation and the worker's regular salary.

Refunds are made to all employers except for the Federal Government. However, in any case where the Federal Government is not continuing to pay full salary, the Board must pay the wage-loss benefits to the worker.

If a claim is reopened and the worker is carried on full salary by a different employer from the employer at the time of the original injury, the new employer is reimbursed to the same extent as the original employer would have been. This applies even though the original 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.

EFFECTIVE DATE:	December 1, 2010 – Delete statement providing 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.
APPLICATION:	Applies to all decisions made on or after December 1, 2010.

#34.41 Vacation Pay

If a vacation period or statutory holiday occurs while a worker is receiving wage-loss benefits, the Board continues to pay those benefits or, in the case of a pay employer claim, to the employer.

#34.42 Termination Pay

The language of section 34(1) is broad enough to cover termination pay.

In a Board decision, the worker suffered a compensable injury on October 28. On October 30, the employer terminated the service of the worker, and pursuant to section 19 of the *Mines Act*, the worker received a termination payment roughly equivalent to wages for one month. The Board rejected an application that the compensation payments attributable to the month of November should be paid to the employer under section 34(1).

This was not a voluntary payment by the employer. It was termination pay required by law. If the worker had been fit to do so, he would have been free in early November to take any other job that he could find, receive full wages in respect of that job and still be entitled to the termination pay. In other words, by the law of the Province, he was entitled to be paid twice over the month of November. Given his disability, he could not do that. But upon being fit again to return to work, he is in the position of one who must find new employment. Termination pay is intended to allow for his being in that position.

This relates only to termination pay under the *Mines Act*. Other arguments may be relevant with regard to other kinds of termination payments. However where the payment is of a similar type or category in that it results from a legislative requirement or a contractual agreement, it will likely be treated in the same manner as that described above.

#34.50 Duration of Wage-Loss Payments

See policy item #35.30 for the rules related to the duration of temporary disability benefits.

#34.51 Other Factors Prevent Return to Employment

Where a worker has not attained the age at which compensation payments are terminated under section 23.1 of the *Act* and the temporary total disability remains, wage-loss payments continue to be paid even though some event occurs after their commencement which would in any event have meant that the worker would not be working. Therefore such benefits are not terminated just because there is a strike, vacation, or lay-off. On the other hand, as pointed out in policy item #34.32, on a recurrence of a compensable condition occurring more than three years after the injury, wage loss will not be paid for any temporary total disability where there is at that time no actual or potential loss of earnings.

Where 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. The Board will then consider the following matters:

(a) If travelling outside the province, the worker should be advised that the Board will not pay in excess of the rates paid for medical treatment in this province.

(b) If there is to be a period with no treatment which may protract recovery, the worker will be advised not to discontinue treatment and that if the worker does so, it may affect entitlement to benefits. The Board will normally seek medical advice before doing this.

(c) The activities planned for the vacation may suggest that the worker is not disabled or may protract recovery. The Board will seek medical advice on this and advise the worker accordingly.

There is in general no objection to wage-loss benefits being continued while a worker is travelling on vacation where that vacation will not hinder or protract recovery. (4)

If a worker's physical impairment has disappeared or stabilized, wage loss must be terminated even though the worker, to prevent further occurrences of his or her condition, remains off work. Compensation is not payable for preventive

measures. Alternatively, if the worker's continuing unemployment is due to factors such as fire hazard, seasonal closure, strike or lock-out, benefits are also not payable. Where, however, there is a delay in return to work due to the travelling required back to the place of employment, such as a previously injured worker returning to the home community from a treatment centre elsewhere or a few days until a company doctor clears the worker to return to work, the Board may extend full wage-loss benefits for a few days beyond the time when the disability ceased. This extension will not be granted if it is concluded that the worker is unnecessarily delaying the return to work.

EFFECTIVE DATE: June 1, 2009 – Delete references to Board officers.
APPLICATION: Applies on or after June 1, 2009

#34.52 Workers Undergoing Educational or Training Program

Where a worker who has been receiving payments 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.

There appear to be three different situations:

1. Retraining or Educational Program Covered by policy C11-88.50

   In certain cases, as outlined in policy C11-88.50, the Board supports retraining or educational programs needed wholly or partly as rehabilitation for a worker's compensable injury. This applies when a worker is no longer disabled from working and temporary disability payments have terminated, but before she or he can return to work some retraining or educational program is required. Policy item #34.52, however, is intended to deal with a worker who undertakes a course of training while receiving compensation for temporary disability under section 29 or 30 of the *Act* and does not affect the operation of policy C11-88.50.

2. Retraining or Educational Program Arranged Prior to 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. Where 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 Human Resources and Skills Development Canada 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 compensation 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 Human Resources and Skills Development Canada for any training allowance to be paid to the employer. The Board would expect that an employer would continue a worker's salary while taking the course, regardless of the fact that the worker had previously received a compensable injury. In this case, the worker suffers no financial loss because of the injury while taking the course and no wage-loss compensation is payable. Nor is the employer refunded the continuation of salary paid to the worker during the course.

In some circumstances, Human Resources and Skills Development Canada 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 to a worker while taking a training course, it is understood that any entitlement of the worker to have the training allowances "topped up" by Human Resources and Skills Development Canada 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. Retraining or Education Program Arranged After the Injury

A worker may decide after the injury to utilize the time in which he or she is disabled from work to improve education or work skills by undertaking a retraining or educational program. The worker is losing time from work because of the injury and is "disabled" for the purposes of section 29 or 30. It cannot be said that even if the worker had not been injured he or she would have been taking the program at that particular time and, as a result, suffering a loss of income. The worker is only taking the program at that particular time because of the injury. Therefore, wage-loss payments will be continued in full in addition to any training allowances which the worker is entitled to receive from another government agency.

EFFECTIVE DATE: June 1, 2009 – Update references to Human Resources and Skills Development Canada.

HISTORY: November 1, 2002 – Amendments to update policy cross-references and housekeeping changes.

APPLICATION: Applies on or after June 1, 2009

#34.53 Termination at a Future Date

A worker is not entitled to place absolute reliance on a doctor's probable return to work date. Wage-loss benefits are only payable when the worker actually has a temporary disability. They cannot be paid because, although the worker has no such disability, the doctor some time previously predicted that he or she would be disabled at that time. A doctor's prediction is of assistance to the worker, the employer and the Board to plan their future actions, but there is no guarantee that the prediction will be accurate. A worker who has been told by the doctor that he or she can probably return to work on some future date has a responsibility to monitor the improvement in his or her condition and to return to work before the predicted date if the condition allows it. If the worker is in any doubt, an earlier appointment can always be arranged with the doctor.

If a doctor's prediction of the duration of a worker's disability were accepted as conclusive, it would mean that if a worker continued to be disabled after a predicted return to work date, he or she should nevertheless return to work. Regardless of a doctor's prediction of the length of a disability, wage-loss benefits are paid for as long as a worker continues to be disabled because of the injury or until the worker has attained the age at which compensation is terminated under section 23.1 of the *Act*. A doctor's prediction of a worker's return to work can be in error by setting a date either too early or too late. It cannot therefore be regarded as the sole criterion for the payment of benefits and is only one factor to be considered.

As a general rule, decisions relating to compensation should relate to the past and the present, and to continuing situations. A termination date should not normally be set for the future. But there are exceptional cases in which a decision of this kind is justified. The responsibilities of the Board relate not only to claims decisions, but also to rehabilitation. Effective rehabilitation requires that different people should be treated in different ways. All people are not motivated by the same approach. It is possible to conceive of cases in which the Board might feel that a worker has reached a point of recovery at which he or she is very close to returning to work. The worker may have a psychological impairment that persuades the Board to continue a convalescent period to enable the worker to adapt. But a judgment might rationally be made that the worker is more likely to adapt his or her thinking to a return to work if told of a specified date at which compensation benefits will terminate. But if, at or after that date, no request for review by the Review Division has been filed and it is within the 75-day period for Board reconsiderations, there is evidence that the worker is still unfit, then the decision can be reconsidered.

EFFECTIVE DATE: March 3, 2003 (as to reference to Review Division and 75-day period for the Board reconsiderations)

APPLICATION: Not applicable.

#34.54 When is the Worker's Condition Stabilized

When a worker is medically examined to assess the degree of impairment, the examining doctor must first determine whether the worker's condition has stabilized. The examining doctor will decide whether:

(a) the condition has definitely stabilized;

(b) the condition has definitely not yet stabilized;

(c) he or she is unable to state whether or not the condition has definitely stabilized and

(i) there is a likelihood of minimal change; or

(ii) there is a likelihood of significant change.

Having regard to the examining doctor's report and any other relevant medical evidence, the Board will then decide whether or not the worker's condition is permanent to the extent that a permanent disability award should be assessed.

In the case of (a), the condition is considered permanent and the permanent disability award is immediately assessed. A condition will be deemed 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 condition is still temporary and the worker will be maintained on temporary wage-loss benefits under section 29 or 30 of the *Act*.

In the situations where the examining doctor in (c)(i) above feels there is only a potential for minimal change, the condition will usually be considered as permanent and the permanent disability award established immediately on the basis of the prognosis. This approach will be particularly helpful where the disability is itself minor.

The following guidelines operate in (c)(ii) above where there is a potential for significant change in the condition.

1. If the potential change is likely to resolve relatively quickly (generally within 12 months), the condition will be considered temporary and the worker maintained on temporary wage-loss benefits under section 29 or section 30 of the *Act*, and a further examination will be scheduled.

2. If the potential change is likely to be protracted (generally over 12 months), the condition will be considered permanent and the permanent disability award assessed and paid immediately on the worker's present degree of disability and the claim scheduled for future review.

The examining doctor may be unable to fit the worker's condition exactly into one of the categories discussed above. In such a case, the doctor should simply state the findings in terms of the categories as well as possible and the question whether the condition is temporary or permanent will have to be dealt with by the Board on the merits of the case.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officers.
HISTORY:	March 3, 2003 – Deletion of reference to pension review.
APPLICATION:	Applies on or after June 1, 2009

#34.55 Subsequent Non-Compensable Incidents

If a subsequent non-compensable incident occurs at a time when a worker is still recovering from his or her 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 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 and only to the extent of that disability. For this reason, the Board will not pay for periods of disability caused by a subsequent non-compensable incident.

If a worker is still disabled by a compensable injury 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 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 or the subsequent non-compensable incident that has aggravated the compensable injury. If the disability is due to the subsequent non-compensable incident, wage-loss benefits are terminated. However, if the disability is due to the compensable injury, wage-loss benefits may be continued.

In the marginal cases, it is impossible to do better than weigh the medical evidence related to the compensable injury against the medical evidence related to the subsequent non-compensable incident to reach a conclusion on the termination of wage-loss benefits. The standard of proof is the balance of probabilities and consideration is given to section 99(3) of the *Act*.

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 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.

EFFECTIVE DATE: August 1, 2010
APPLICATION: This policy applies to all decisions made on or after August 1, 2010.

#34.60 Payment Procedures

The decision whether wage-loss benefits are payable, the duration of those payments, and their amount, is made by the Board. The procedures followed in making this decision, including the rules of evidence followed, are dealt with in Chapter 12.

Payments of wage-loss benefits are usually made every two weeks. Cheques may be mailed to the worker. When 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.

Where a worker disagrees with the amount of wage-loss or permanent disability award 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 his or her permanent disability award cheque by electronic funds transfer.

Where, following a Board medical examination or the receipt of other reports, it is concluded that the worker is capable of resuming employment immediately, she or he will be notified as soon as possible. The Board recognizes that it would not be fair to delay the notification when the worker might be looking for employment in the meantime.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officers and inclusion of reference to funds transfer.
HISTORY:	March 3, 2003 – Inclusion of reference to the Review Division.
APPLICATION:	Applies on or after June 1, 2009

#35.00 TEMPORARY PARTIAL DISABILITY PAYMENTS

Section 30(1) provides that**:**

> Subject to sections 34(1) and 35(1), (4) and (5), if a temporary partial disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment 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.

#35.10 Meaning of Temporary Partial

The meaning of "temporary partial" is governed by the principles set out in policy item #34.10. The result is that in order to be eligible for benefits under section 30(1) a worker must have a temporary partial physical impairment as a result of the injury.

Workers will also be considered to have a temporary partial disability when, even though they would ordinarily be considered as temporarily totally disabled, they do in fact continue to carry out their previous jobs in part or perform some other type of light work.

#35.11 Procedure for Determining Whether Worker is Temporarily Partially Disabled

The decision as to whether a disability has resolved to a point of recovery where it is deemed to be only "partial" shall be made by the Board on the best evidence available. In many cases it may be appropriate to rely solely upon reports of the worker's attending physician or a consulting specialist. Medical advice on the contents of such reports should be sought and it may be prudent to contact the attending physician for further discussion.

In other cases, it might well be necessary for the Board to have the worker medically examined.

In either case, what must be determined is whether the worker's medical condition has resolved to the point where he or she is no longer to be considered "totally" disabled and it would be to his or her advantage to begin to consider re-entry into the work force. It will not be necessary for the Board to wait passively for notification by an attending physician or consulting specialist before proceeding to deal with the worker's condition as a "partial" rather than "total" condition. There may be cases where the Board should instigate an examination of the worker in order to determine the extent of the condition, particularly where recovery from the injury appears to be unusually protracted, or it appears that other health or social problems are complicating the potential for re-employment, or where medical reports tend to indicate considerable improvement in the worker's medical condition without specifically recommending a return to some form of employment.

In any case where it is deemed necessary to have the worker medically examined, claims will be referred promptly for that purpose and the examination will be given priority. Where such an examination is conducted, the report will indicate whether the worker is:

(a) still totally disabled;

(b) fully recovered;

(c) temporarily partially disabled;

(d) suffering from a residual permanent disability which shows no reasonable likelihood of change.

Where it is found that the worker is temporarily partially disabled, the medical examination report will include:

(a) an estimate of the period required for full recovery or stability;

(b) a recommendation for a future examination;

(c) any medical restrictions to re-employment, such as limitations on lifting activities, with the reason for such restrictions;

(d) any medical or other factors found in the examination which are considered significant in the determination of the worker's recovery process.

Where the Board intends to rely upon a report from the worker's attending physician or consulting specialist, these same general questions should be clarified through contact with that physician before any further action is taken.

Where a worker is medically judged to be only partially disabled and the condition remains temporary, any further wage-loss payments should then be processed under section 30 of the *Act.* In cases where the Board is able to arrange a return to work in a suitable occupation, a referral for vocational rehabilitation assistance may not be required. However, immediate referral for vocation rehabilitation assistance is made if a suitable return to work cannot be arranged, or if a comprehensive employability assessment needs to be completed.

The Board must send a letter to the worker, with a copy to the employer and doctor, advising:

(a) that the worker is considered to be only partially disabled;

(b) that further wage-loss benefits will be paid on the basis of the difference between the earnings before the injury and what the worker is then earning, or will be able to earn, whichever is considered appropriate;

(c) in cases where vocational rehabilitation assistance is required, that the worker will be contacted and interviewed by the Board to assist in efforts to return to work;

(d) the proposed date of the next examination and therefore the length of time for that phase of payments under section 30.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officers, Board Medical Advisors and Vocational Rehabiliation Services.
HISTORY:	November 1, 2002 – Amendments to clarify that a Board officer may make a referral to Vocational Rehabilitation Services to assist with arranging a return to work.
APPLICATION:	Applies on or after June 1, 2009

#35.20 Amount of Payment

Section 30 provides for payment of partial or total wage-loss benefits where a worker is only partially disabled. Once the determination is made, on medical grounds, that a worker is no longer totally disabled but in fact has reached a point in the recovery process where he or she is deemed to be only partially disabled, section 30 requires that compensation be paid at 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.

Compensation paid under section 30, represents a worker's post-injury wage loss over the short-term and is based on the worker's post-injury earning capacity. Accordingly, in making this determination, the Board considers what a worker is estimated to be capable of earning in a suitable occupation. This requires an employability assessment. (See policy C11-89.00, "Employability Assessments – Temporary Partial Disability and Permanent Partial Disability").

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, what the worker is estimated to be capable of earning is deducted from the pre-injury earnings to arrive at the worker's post-injury wage loss.

A worker's post-injury wage 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 his or her earning capacity up to the pre-injury wage rate; or

- The worker has, for personal reasons, withdrawn from the workforce; or

- The worker fails to co-operate with the rehabilitation process.

The compensation rate established under section 30 is subject to periodic review. The review may include a vocational rehabilitation assessment regarding what the worker actually earned in the intervening period, if anything, and will estimate what the worker could have earned in the opinion of the Board. Payments by the Board will be based upon this information and on any other evidence considered significant.

In determining temporary partial disability entitlement under section 30 of the *Act*, no earnings losses incurred are considered where such losses are in excess of the amount of personal optional protection purchased.

The Board shall, in all cases, make the worker aware of the reasons for the payments being made under section 30 and more particularly, when only partial payments are made.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officers, Compensation Services and Vocational Rehabilitation Services.
HISTORY:	November 1, 2002 – Amendments set out section 30 and provides that compensation paid under section 30 represents a worker's post-injury wage loss over the short term and is based on the worker's post-injury earning capacity. Policy also provides cases where post-injury wage-loss will be based on estimated earnings rather than on actual earnings.
APPLICATION:	Applies on or after June 1, 2009

#35.21 Suitable Occupation

A suitable occupation is one that:

- does not endanger a worker's recovery or the health and safety of the worker and/or others;

- the worker has the skills, education and functional abilities that the occupation requires;

- is reasonably available over the short-term in the worker's community or, where appropriate, in the Province at large; and

- a worker is medically capable of performing.

Once a suitable occupation is identified, the Board will estimate what the worker is capable of earning in that occupation. In calculating what the worker is capable of earning in the suitable occupation, there may be situations where the Board should also consider other factors. These factors include:

- any personal limitations upon re-employment, such as age or language;
- any external limitations upon re-employment, such as the possibility of loss of pension entitlement or seniority;
- limitations through the worker's own efforts and cooperation in becoming re-employed;
- general or local depressed economic conditions which limits the worker's re-employment irrespective of the occurrence of the injury.

There must be objective evidence that these factors either alone or in combination would make it unreasonable for the Board to consider that occupation as suitable for the purpose of establishing what the worker is estimated capable of earning. These factors must be balanced against the goal of minimizing post-injury wage-loss.

With regard to economic conditions, the Board has to determine whether the worker's employment problem is primarily due to a residual temporary disability or is more likely to be due to the lack of suitable employment occasioned by economic circumstances.

Where the economy is the major factor in a worker's post-injury wage loss, compensation under section 30 is based on the difference between the worker's pre-injury wage rate and the wage rate of the jobs that would otherwise have been available were it not for the economic down-turn. However, where the worker's remaining disability makes him or her less viable as a potential candidate for employment in the labour force in competition with other non-disabled workers, the worker may be paid full benefits on the basis that the work is not reasonably available.

If economic conditions are such that had the worker not been injured**,** he or she also would have continued to be employed, then, even though alternative jobs are not available due to economic factors, the primary cause of the worker's loss is considered to stem from the injury. The worker is entitled to section 30 benefits up to and including full wage-loss benefits if there are no jobs reasonably available in the period being considered.

If a worker is working towards an employment objective under a rehabilitation plan, the worker is not expected to accept a lower paying alternative job in the interim, if the worker is cooperating in good faith and taking the job would negatively compromise the rehabilitation plan.

In all cases, the employment opportunity or opportunities should be available immediately or within the period under review (two weeks, one month) and there should be some certainty that workers would have these opportunities open to them should they choose to apply.

EFFECTIVE DATE: November 1, 2002
APPLICATION: To decisions made on or after November 1, 2002 on claims adjudicated under the *Act*, as amended by the *Workers Compensation Amendment Act, 2002.*

#35.22 Calculation of Earnings for Workers with Two Jobs

Where, prior to the injury, the worker was engaged in two occupations, but the injury only disables the worker from one, the pre-injury earnings are calculated by adding the earnings in both, subject to the statutory maximum. The post-injury earnings are calculated by combining the earnings in the job the worker continues to carry on, with the earnings (if any) which the worker is able to earn in some other suitable and available job in the time that would have otherwise been spent in performing the other pre-injury job.

#35.23 Minimum Amount of Compensation

The minimum amount of compensation is calculated in the manner set out in policy item #34.20 for temporary total disability but to the extent only of the partial disability. (5)

Where a worker's average earnings are less than the minimum, he or she will receive compensation equal in amount to his or her loss of earnings in any case where section 30 applies. Compensation in these situations will not be based upon 90% of average net earnings. Consequently, there will be no deductions from the worker's average earnings to produce average net earnings.

#35.24 Workers Engaged in Own Business

Where the worker is self-employed, the worker will often continue to work following a compensable injury. Though unable to perform the former heavier work, the worker can still perform administrative and other light work. Full wage-loss benefits will not be paid by the Board just because the worker cannot perform the heavier work. As the worker is doing some remunerative work,

section 30 requires that it be taken into account, and that only partial wage-loss benefits be paid.

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

Where the worker was not engaged in his or her own business prior to the injury, and the worker commences a business after the injury, the following applies. Being in control of the business, the worker determines what personal salary is paid. The worker can, and will commonly, take no earnings at all, or very low earnings, out of the business when it is starting up in the expectation that he or she will reap the benefit later. Yet, the worker may be doing a substantial amount of work that, under normal circumstances, would command a significant wage. In such a situation, the only way the Board can determine the worker's real earnings is to estimate the value of the work the worker does.

#35.30 Duration of Temporary Disability Benefits

Section 31.1 of the *Act* provides that:

> Despite section 23.1, the Board may not make a periodic payment to a worker under section 22(1), 23(1) or (3), 29(1) or 30(1) if the worker ceases to have the disability for which the periodic payment is to be made.

As a result, the Board will terminate temporary total or temporary partial wage loss benefits under section 29(1) or 30(1) once the worker's temporary disability ceases. A temporary disability ceases when it either resolves entirely or stabilizes as a permanent impairment, entitling the worker to be assessed for a permanent disability award under section 22 or 23 of the *Act*.

The nature of a temporary disability may also change, affecting a worker's entitlement under the *Act*. Benefits payable under section 29(1), will be terminated if the worker's medical condition has resolved to the point where he or she is no longer considered temporarily totally disabled and becomes temporarily partially disabled. In these situations, the worker may be entitled to compensation under section 30(1) of the *Act*.

Similarly, benefits payable under section 30(1) will be terminated if the worker's compensable medical condition ceases to be "temporary partial" and becomes "temporary total". The worker in such circumstances may be entitled to compensation under section 29(1) of the *Act*.

In all cases, benefits will be terminated under sections 29(1) and 30(1) where, notwithstanding the existence of a temporary total or temporary partial impairment, the worker is suffering no loss of earnings as a result of the work injury.

Finally, the duration of temporary benefits may be affected by the worker's age at the date of injury.

Section 23.1 of the *Act* provides that compensation under section 22(1), 23(1) or (3), 29(1) or 30(1) may be paid to a worker, only:

(a) if the worker is less than 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; or

(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) two years after the date of the injury; or

(ii) if the Board is satisfied that the worker would retire after the date referred to in subparagraph (i), the date

Section 23.1 of the *Act* provides for the payment of compensation until a worker reaches 65 years of age.

Where the Board is satisfied a worker would retire after reaching 65 years of age, section 23.1 permits the Board to continue to pay benefits to the age the worker would retire after the age of 65 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 (eg. CPP, OAS, employer pension plan, RRSP or other personal savings).

When determining whether a worker would retire after age 65, the circumstances under consideration are those of the individual worker as they existed at the time of injury.

The standard of proof under the *Act* is on a balance of probabilities as described in policy item #97.00, Evidence. However, as age 65 is the established retirement age under the *Act*, the Board requires evidence that is verified by an independent source to confirm the worker would work past age 65. Evidence is also required so that the Board can establish the worker's new retirement date for the purposes of concluding wage loss benefits.

Examples of the kinds of independent verifiable evidence that may support a worker's statement that he or she intended to work past age 65, and to establish the date of retirement, include the following:

- names of the employer or employers the worker intended to work for after age 65, a description of the type of employment the worker was going to perform, the expected duration of employment, and information from the identified employer or employers to confirm that he or she intended to employ the worker after the worker reached age 65 and that employment was available;

- a statement from a bank or financial institution outlining a financial plan and post age 65 retirement date, established prior to the date of the injury; and

- an accountant's statement verifying a long-term business plan (for self-employed workers) established prior to the date of the injury, indicating continuation of work beyond age 65.

Where the above type of evidence is available, this would be positive evidence in support of a determination that a worker would have worked until after age 65.

The following are examples of other kinds of independent verifiable evidence that alone may not be determinative of whether a worker would retire after reaching 65 years of age:

- information provided from the worker's pre-injury employer, union or professional association regarding the normal retirement age for workers in the same pre-injury occupation and whether there are incentive plans for workers working beyond age 65;

- information from the pre-injury employer about whether the worker was covered under a pension plan provided by the employer, and the terms of that plan information from the pre-injury employer or union on whether there was a collective agreement in place setting out the normal retirement age information regarding whether the worker would have the physical capacity to perform the work;

- financial obligations of the worker, such as a mortgage or other debts;

- family commitments of the worker; and
- an outstanding lease on a commercial vehicle (for self-employed workers).

These are not conclusive lists of the types of evidence that may be considered. The Board will consider any other relevant information in determining whether a worker would have worked past age 65 and at what date the worker would have retired.

The issue for the Board to determine is whether there is sufficient positive evidence that it is more likely than not that the worker would have retired after age 65. In order to make this determination, the Board considers a worker's statement of intention to retire after age 65 and looks for evidence that is verified by an independent source to support the worker's statement.

Generally, the decision as to a worker's retirement date is made as part of the determination of a worker's entitlement to a permanent disability award.

In some circumstances, the decision as to a worker's retirement date may be made prior to the determination of a worker's entitlement to a permanent disability award. For example, when a worker's retirement date impacts a worker's entitlement to temporary disability or vocational rehabilitation benefits. In these cases, the retirement date on the temporary disability or vocational rehabilitation benefit will also apply to the resulting permanent disability benefit, if awarded.

Where the Board is satisfied that a worker would have continued to work past age 65 if the injury had not occurred, wage loss payments may continue past that age until the date the Board has established as the worker's retirement date. At the worker's age of retirement, as determined by the Board, wage loss payments will conclude even if the worker's temporary disability remains.

EFFECTIVE DATE: June 1, 2014
APPLICATION: Applies to all decisions on or after June 1, 2014

#35.40 Manner of Payment

Temporary partial disability payments are made in the same manner as temporary total disability payments. (7)

NOTES

(1) See policy item #34.54

(2) s.29(2)

(3) See policy item #34.40

(4) See Items C10-75.10, C10-73.00

(5) s.30(2)

~~(6) Earnings and Employment Trends, Jan/Feb 2001, BC Statistics, Ministry of Finance and Corporate Relations, Province of British Columbia.~~**DELETED**

(7) See policy item #34.60

CHAPTER 6

PERMANENT DISABILITY AWARDS

#36.00 INTRODUCTION

Permanent disability awards are made when a worker fails to completely recover from a work-related injury or occupational disease, but is left with a permanent residual disability. They commence at the point when the worker's temporary disability under the claim ceases and the condition stabilizes. They may be total (section 22) or partial (section 23).

Permanent disability awards 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.

#36.10 Transitional Provisions for Permanent Disability Awards (see Chapter 1, policy item #1.03)

#36.20 Canada Pension Plan Disability Benefits

Section 34(2) of the *Act* provides:

> Subject to sections 7(4.1), 22(2) and 23(4), the Board must deduct, from the amount of a periodic payment of compensation paid to a worker under section 22(1) or 23(1) or (3) for an injury, an amount equal to 50% of any disability benefit that the worker is paid in respect of the injury under the *Canada Pension Plan*.

The Board deducts applicable Canada Pension Plan ("CPP") disability benefits from a worker's permanent disability award 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 award.

Where a worker is paid CPP disability benefits for his or her dependent children, the Board does not deduct CPP disability child benefits from the worker's permanent disability award.

#36.21 Confirmation of CPP Disability Payments

The Board will advise a worker of the legislative requirement that CPP disability benefits be deducted from the worker's permanent disability award. To ensure that only the portion of CPP disability benefits related to the injury is deducted from a worker's permanent disability award, the Board needs information from Human Resources and Skills Development Canada 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 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 policy item #93.26.

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 policy item #93.26.

EFFECTIVE DATE: June 1, 2009 – Update references to Human Resources and Skills Development Canada.

APPLICATION: Applies on or after June 1, 2009

#36.22 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.

When 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 injury, 50% of the entire CPP disability benefits paid to the worker will be deducted from the worker's permanent disability award payable by the Board.

Where 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:

- Where the permanent disability award is calculated under the section 23(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 23(1) method. The Board deducts 50% of the calculated amount from the worker's permanent disability award.

- Where the permanent disability award is calculated under the section 23(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 award.

Where 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 award.

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

#36.23 Deduction of Lump Sum Payments of CPP Disability Benefits

Where the Board determines a worker's permanent disability award entitlement and the worker is later advised that he or she 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 entitlement. 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.

#36.24 Deduction of CPP Disability Benefits in Cases of Minimum Compensation

A statutory minimum amount of compensation applies to a permanent disability award paid to a worker. CPP disability benefits will be deducted until the resulting permanent disability award amount falls to the statutory minimum.

If the permanent disability award is at or below the statutory minimum, the Board will not deduct CPP disability benefits.

#37.00 PERMANENT TOTAL DISABILITY

Section 22(1) of the *Act* provides:

> Subject to sections 34 and 35, if a permanent total disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment that equals 90% of the worker's average net earnings.

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 have worked past age 65. (Policy item #41.00)

On reaching retirement age, a worker who has received a permanent disability award is entitled to a retirement benefit (policy item #116.00). Permanently totally disabled workers are also entitled to rehabilitation and health care services and personal supports after reaching retirement age (policy item #116.30). Board policies on the retirement benefit are contained in Chapter 18 of the *RS&CM*.

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

#37.10 Commencement of Permanent Total Disability Payments

Awards for permanent total disability 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 these payments at a provisional rate pending clarification of the worker's pre-injury earnings. (1)

Following the calculation of a worker's permanent total disability award, the Board must deduct from a worker's periodic payment an amount equal to 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 (policy items #36.20 to #36.24).

#37.20 Minimum Amount of Compensation

Section 22(2) provides that the compensation awarded for permanent total disability cannot be less per month than the minimum set out below. This minimum is subject to cost of living adjustments as described (policy item #51.20).

			$ Minimum
January 1, 2018	—	December 31, 2018	1,759.04
January 1, 2019	—	December 31, 2019	1,802.04

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

#37.21 Statutory Minimum Application

The statutory minimum only applies in cases where a worker is found to be 100% disabled under the section 23(1) method of permanent disability assessment. It does not apply when the percentage of disability is less than 100% but the worker is found to be totally unemployable under the section 23(3) method of permanent disability assessment. (2)

#37.30 Reopening Claims

Where a claim involving a permanent total disability is reopened, no payments of wage loss can be made. Wage loss may, however, be payable where a worker receiving a permanent total disability award of less than the current maximum suffers a new injury at work. The amount payable would be the difference between the 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.

#38.00 COMPENSATION FOR PERMANENT PARTIAL DISABILITY

Section 23 of the *Act* pertains to the determination of a worker's entitlement to compensation for a permanent partial disability award. An award granted under section 23 compensates a worker for permanent partial disability that results from a work injury. Section 23(1) is the mandatory provision that must be applied in the assessment of permanent partial disabilities. Only in exceptional circumstances will an assessment be done under section 23(3).

In all cases where a permanent partial disability results from a work injury, a worker's entitlement to a permanent partial disability award must be calculated using the method set out in section 23(1) of the *Act.* In determining the

compensation payable under 23(1), the Board may be guided by section 23(2), which permits the use of a schedule of percentages of impairment of earning capacity for specified injuries or mutilations.

In all but exceptional cases, the effect of the disability on a worker will be appropriately compensated under section 23(1).

Only in exceptional cases will section 23(1) not be the method of assessment used to determine a worker's entitlement to a permanent partial disability award. In these cases the Board considers whether the combined effect of a worker's occupation at the time of injury and the disability resulting from the injury is so exceptional, that the section 23(1) method does not appropriately compensate the worker for the injury. In these exceptional cases, the Board has the discretion to assess a worker's entitlement to a permanent partial disability award under section 23(3) of the *Act*.

#39.00 SECTION 23(1) ASSESSMENT

Section 23(1) of the *Act* provides:

> Subject to subsections (3) to (3.2) and sections 34 and 35, if a permanent partial disability results from a worker's injury, the Board *must*
>
> (a) estimate the impairment of earning capacity from the nature and degree of the injury, and
>
> (b) pay the worker compensation that is a periodic payment that equals 90% of the Board's estimate of the loss of average net earnings resulting from the impairment.

(emphasis added)

In all cases where a permanent partial disability results from a worker's injury, the Board must assess the worker's entitlement to a permanent partial disability award under section 23(1) of the *Act*. Section 23(1) is a mandatory legislative provision which sets out the rule the Board follows in determining a worker's impairment of earnings capacity resulting from a work injury.

The percentage of disability determined for the worker's condition under section 23(1)(a), reflects the extent to which a particular injury is likely to impair a worker's ability to earn in the future.

A permanent partial disability award calculated under section 23(1) also reflects 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 a permanent partial disability award under section 23(1), the Board may make reference to section 23(2) of the *Act*. Section 23(2) of the *Act* provides

> The Board may compile a rating schedule of percentages of impairment of earning capacity for specified injuries or mutilations which may be used as a guide in determining the compensation payable in permanent 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 award is 90% of the amount so determined. The permanent partial disability award is granted following the determination of a worker's entitlement under section 23(1) of the *Act*.

Under the section 23(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.

#39.01 Decision-Making Procedure under Section 23(1)

Section 23(1) assessments are undertaken once a worker reaches medical plateau.

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 a permanent partial disability award.

Section 23(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 injury and other relevant criteria as set out in the protocols. The Board may determine the worker's section 23(1) entitlement without a medical examination, if there is sufficient medical information on file to complete the assessment.

The determination of whether there is a permanent psychological impairment, and the severity of the impairment, is made by either the Board or a Board authorized External Service Provider. Once this evaluation is completed, the claim is referred to the Psychological Disability Committee to assess the percentage of disability resulting from the permanent psychological impairment.

The Board assesses any percentage of disability for physical impairment and, in conjunction with the Committee's percentage of psychological disability, determines the worker's permanent disability award under the section 23(1) method.

EFFECTIVE DATE:	June 1, 2009 – Remove references to Board officer, Rehabilitation and Compensation Services Division, Disability Awards Medical Advisor and Board authorized External Service Provider.
HISTORY:	August 1, 2003 – housekeeping changes.
APPLICATION:	Applies on or after June 1, 2009.

#39.02 Chronic Pain

This policy sets out guidelines for the assessment of section 23(1) awards for workers who experience disproportionate disabling chronic pain as a compensable consequence of a physical or psychological work injury.

1. 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.

2. Multidisciplinary Assessment:

Where a worker has been referred for a permanent partial disability assessment under section 23(1) for chronic pain, the Board may refer the worker for a multidisciplinary assessment. (See Item C3-22.20, *Compensable Consequences - Pain and Chronic Pain*)

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, *Compensable Consequences - Pain and Chronic Pain*)

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.

3. Evidence Considered in a Chronic Pain Section 23(1) Assessment:

In making a determination under section 23(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 23(1) assessment for chronic pain includes the following:

i) The findings of any multidisciplinary assessments.

ii) Information provided by the worker's attending physician as well as any other relevant medical information on the claim.

iii) The worker's own statements regarding the nature and extent of the pain.

iv) The worker's conduct and activities and whether they are consistent with the pain complaints.

v) 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 a section 23(1) award must be fully documented.

4. Entitlement to a Section 23(1) Assessment:

Entitlement to a section 23(1) award for chronic pain may only be considered after all appropriate medical treatment and rehabilitation interventions have been concluded.

(a) Specific Chronic Pain – Consistent with the Impairment

Where a worker has specific chronic pain that is consistent with the associated compensable physical or psychological permanent impairment, the section 23(1) award will be considered to appropriately compensate the worker for the impact of the chronic pain. 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, an additional award for the specific chronic pain will not be provided, as it would result in the worker being compensated twice for the impact of the pain.

(b) Specific and Non-Specific Chronic Pain – Disproportionate to the Impairment

A worker's entitlement to a section 23(1) award for chronic pain will be considered in the following cases:

i) Where a worker experiences specific chronic pain that is disproportionate to the associated objective physical or psychological impairment.

   Pain is considered to be disproportionate where 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, a separate section 23(1) award for chronic pain may be considered in addition to the award for objective permanent impairment.

ii) Where a worker experiences disproportionate non-specific chronic pain as a compensable consequence of a work injury or disease.

Disproportionate pain, for the purposes of this policy, is pain that is significantly greater than what would be reasonably expected given the type and nature of injury or disease.

Where the Board determines that a worker is entitled to a section 23(1) award for chronic pain in the above noted situations, an award equal to 2.5% of total disability will be granted to the worker.

EFFECTIVE DATE: June 1, 2009 – Delete references to Board officers.
HISTORY: January 1, 2003 – Amendments set out guidelines for the assessment of section 23(1) awards for workers who experience disproportionate disabling chronic pain as a compensable consequence of a physical or psychological work injury. Amendments apply to new claims received and all active claims that are currently awaiting an initial adjudication on or after January 1, 2003.
APPLICATION: Applies on or after June 1, 2009

#39.10 Permanent Disability Evaluation Schedule

Section 23(1) awards may be made with reference to the *Permanent Disability Evaluation Schedule* ("*Schedule*"), which is set out in Appendix 4. This is a rating schedule of percentages of disability for specific injuries or mutilations. (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 award; 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*. (4)

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 loss of function in the damaged area. This determination is based on the findings of the section 23(1) evaluation and other medical and non-medical evidence available. The final award 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 award 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 scheduled at 70% of total disability. Suppose a worker suffers a severe crush injury to the arm which culminates in a permanent loss of half its function. The final assessment would be 50% of 70%, i.e. 35% of total disability.

EFFECTIVE DATE: June 1, 2009 – Delete references to Board officers.
HISTORY: Consequential amendments arising from changes to the Permanent Disability Evaluation Schedule were made effective January 1, 2015.
August 1, 2003 – Deletion of statements regarding revisions to the *Schedule* and housekeeping changes.
APPLICATION: Applies on or after June 1, 2009

#39.20 Non-Scheduled Awards

Any award where the *Schedule* is not directly or indirectly used in the assessment is a non-scheduled award. 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 awards. The rules governing respiratory and skin diseases are set out in policy item #29.00 and policy item #30.50 respectively.

In the case of non-scheduled awards, judgment is used to arrive at a percentage of disability appropriate to the particular claimant's impairment. Regard will be had to, inter alia, the section 23(1) evaluation, the circumstances of the claimant, 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 awards. 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.

EFFECTIVE DATE: June 1, 2009 – Delete references to Board officer.
HISTORY: August 1, 2003 – housekeeping changes.
APPLICATION: Applies on or after June 1, 2009

#39.30 Minimum Award

The minimum compensation for permanent partial disabilities is calculated in the same manner as for temporary total disability but only to the extent of the partial disability. (6) Thus, for example, if a worker is injured on January 2, 1986, and suffers a residual disability assessed at 10% of total disability, the minimum compensation will be the lesser of 10% of $197.25 or 10% of his average earnings prior to the injury.

The minimum for permanent total disability does not apply simply because a worker is found to be totally unemployable under section 23(3). (7)

#39.31 Injury Prior to March 18, 1943

Notwithstanding any other provision of the *Act*, all periodic payments awarded as compensation for permanent partial disability to workers injured prior to March 18, 1943, who, on January 1, 1955, or after that are in receipt of those periodical payments are calculated or recalculated at a rate of sixty-six and two-thirds per cent of average earnings of not less than two thousand dollars nor more than two thousand five hundred dollars per annum. Compensation is not payable under this provision for any period prior to January 1, 1955. (8)

#39.32 Injury Prior to January 1, 1965

In regard to payments made on or after January 1, 1965, permanent partial disability pensions awarded in respect of injuries occurring before that date were 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 would be paid in an amount equal to the average earnings.

Any increase resulting from the above provisions did not apply to a commuted pension or the commuted portion of a pension.

In considering whether the worker's earnings were less than the minimum, the artificial wage created by the application of policy item #39.31 was not taken into account. Only the worker's actual earnings were relevant.

#40.00 SECTION 23(3) ASSESSMENT

Section 23(3) of the *Act* provides:

> Subject to sections 34 and 35, if
>
> (a) a permanent partial disability results from a worker's injury; and
> (b) the Board makes a determination under subsection (3.1) with respect to the worker;
>
> the Board may pay the worker compensation that is a periodic payment that equals 90% of the difference between
>
> (c) the average net earnings of the worker before the injury, and
> (d) 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.
>
> (3.1) A payment may be made under subsection (3) only if the Board determines that the combined effect of the worker's occupation at the time of injury and the worker's disability resulting from the injury is so exceptional that an amount determined under subsection (1) does not appropriately compensate the worker for the injury.

(3.2) In making a determination under subsection (3.1), the Board must consider the ability of the worker to continue in the worker's occupation at the time of injury or to adapt to another suitable occupation.

Section 23(3) is a discretionary provision that establishes rules for compensating a worker for a permanent partial disability in exceptional circumstances. Section 23(3) is only applied where the test set out under section 23(3) and (3.1) is met.

This test requires that the Board determine whether the combined effect of a worker's occupation at the time of injury and a worker's disability resulting from the injury is so exceptional that an amount determined under section 23(1) does not appropriately compensate the worker for the injury.

For the purposes of determining whether the worker meets the test set out under section 23(3) and (3.1), the Board must consider the combined effect of a worker's occupation at the time of injury and the resulting disability. While a worker may experience a loss of earnings as a result of a work injury, that fact alone is not sufficient to meet the test set out under section 23(3) and (3.1).

In all cases, the Board must determine if, following recovery from a work injury, a worker is either able to continue in the occupation at the time of injury or to adapt to another suitable occupation. This determination includes consideration of both the worker's transferable skills and the worker's post-injury functional abilities. In the vast majority of cases a worker's entitlement to a permanent partial disability award is determined under the section 23(1) method and this estimate of impairment of earning capacity is considered to be appropriate compensation.

However, in exceptional cases, the amount determined under section 23(1) may not appropriately compensate a worker. In these cases, the disability resulting from the work injury makes it unlikely that a worker can continue in the occupation at the time of injury or adapt to another suitable occupation, without incurring a significant loss of earnings.

For the purposes of this policy, a significant loss of earnings means the Board may conclude in these exceptional cases, that the loss of earnings a worker will experience as a result of the combined effect of the worker's occupation at the time of injury and the worker's disability resulting from the injury could not have been anticipated under the section 23(1) method of estimating a worker's long term loss of earning capacity.

In determining whether a worker is experiencing a significant loss of earnings, the Board takes into consideration the difference between the worker's pre-injury earnings and the combined total of the worker's post-injury earnings and the amount awarded under the section 23(1) method of assessment.

An example of when the combined effect may be considered so exceptional is one where a work injury results in a significant disability of two digits on the dominant hand of a worker whose occupation requires fine motor skills. As a result of the disability, the worker is no longer able to perform fine motor skills, and consequently, is unable to continue in the pre-injury occupation without incurring a significant loss of earnings. In addition, due to the disability, the worker is unable to adapt to another suitable occupation without incurring a significant loss of earnings.

As a result, the section 23(1) award may not be considered to appropriately compensate the worker for the impact of the combined effect, and the worker therefore may be eligible to be considered for an award under section 23(3).

EFFECTIVE DATE: April 26, 2012

APPLICATION: Applies to all decisions, including appellate decisions, made on or after April 26, 2012.

#40.01 Decision-Making Procedure under the Section 23(3) Method

Section 23(3) assessments are undertaken if a permanent partial disability results from a worker's injury, and the Board makes a determination under subsection (3.1) with respect to the worker.

The Disability Awards Committee is ultimately responsible for the conclusion on permanent partial disability awards assessed under section 23(3) of the *Act*. The Board conducts the necessary investigations and make a specific recommendation to the Committee regarding a worker's eligibility for a section 23(3) assessment and, in cases where an assessment is undertaken, the worker's entitlement to an award.

It is the function of the Committee, following any further investigation it considers necessary, to agree or disagree with the recommendation. If the Committee agrees, the initial recommendation will be implemented. If the Committee disagrees with the recommendation, it will either implement its findings or direct further investigation.

The rules of evidence followed by the Board and the Disability Awards Committee are discussed in policy item #97.40.

A review by the Review Division may be requested regarding a worker's section 23(3) entitlement.

EFFECTIVE DATE: June 1, 2009 – Delete references to Board officer, Medical Services and the Disability Awards Committee.

HISTORY: March 3, 2003 – Inclusion of reference to review.
APPLICATION: Applies on or after June 1, 2009.

#40.10 Section 23(3) Assessment Formula

This assessment is undertaken in exceptional cases where the Board determines that a worker is eligible for an assessment under section 23(3) of the *Act*. The following guidelines apply in considering a worker under section 23(3):

1. Long term average net earnings that the worker is earning after the injury will be determined in accordance with established policies in Chapter 9.

2. In considering the amount that better represents the worker's loss of earnings after the injury, the Board will compare the average net earnings that the worker is actually earning after the injury, with the average net earnings the Board estimates the worker is capable of earning in a suitable occupation after the injury. This comparison requires an employability assessment.

3. In estimating what a worker is capable of earning after the injury, the Board gives regard to the evidence, including the medical evidence, of the limitations imposed by the compensable disability and the fitness of the worker for different occupations. The Board also gives regard to the evidence about the suitability of the worker for occupations that could reasonably become available. Following these considerations, the Board will arrive at a conclusion about suitable occupations that the worker could be expected to undertake over the long-term future.

4. Average net earnings that maximize the worker's long-term potential up to the worker's pre-injury wage rate, will be selected from the occupations that are suitable and reasonably available over the long-term. Earnings in those occupations will be determined as at the time of the injury.

5. The possible award 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.

6. Any increase that may be due to the worker because of a cost of living adjustment will then be added.

7. Since the assessment under section 23(3) aims to predict the worker's actual loss of earnings over the future, no award can be made when the worker is unemployed for reasons unrelated to the

injury and it is determined that there will not be a potential loss of earnings.

These guidelines are discussed further in policy items #40.12 to #40.14.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officer.
HISTORY:	November 1, 2002 – Amendments include the requirement of an employability assessment, and the limitation of "up to the worker's pre-injury wage rate".
APPLICATION:	Applies on or after June 1, 2009

#40.12 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.

In estimating what a worker is capable of earning in a suitable occupation after the injury, the Board gives regard to the evidence, including the medical evidence of the limitations imposed by the compensable disability, and the ability of the worker to perform different occupations. Regard 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 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.

The guidelines set out below are followed in determining suitable and reasonably available occupations for a worker:

- If the worker has made all reasonable efforts to maximize his or her earnings, the job that the worker has actually obtained is generally accepted as being suitable, unless there is evidence that 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 occupation must, in practice, be reasonably available. 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 that a worker will receive all possible promotions that might theoretically be made available.

- The worker has the skills, education and functional abilities that the occupation requires.

- A reasonably available occupation must be one that the worker is medically fit to undertake, and that does not endanger the worker's recovery or the health and safety of the worker and/or others.

- Where a suitable occupation is reasonably available over the long term, it is taken into consideration even though it is not reasonably available at the time of assessment because of general economic conditions.

- In deciding whether it is reasonable for a worker to refuse a job, regard should be had to the long term as well as the immediate job. If jobs in an 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.

- A reasonably available job is usually within a reasonable commuting distance of the worker's home. (See policy C11-88.90, "Relocation".)

- If the worker declines the best-paying reasonably available job because of a personal preference for a lower-paying job or for an alternative life-style, the wage rate in the best-paying reasonably available job will be used in the formula.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officer.
HISTORY:	November 1, 2002 – Policy substantially revised. Clarifies guidelines to be followed in determining suitable and reasonably available occupations for a worker.
APPLICATION:	Applies on or after June 1, 2009

#40.13 Measurement of Earnings Loss

Sections 23(3)(c) and (d) set out the process for determining a worker's entitlement to a permanent partial disability award under this method. These subsections provide that the Board may pay a worker compensation that is a periodic payment that equals 90% of the difference between the average net earnings 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 policy item #40.12 and determining the earnings figure which will maximize the worker's long-term earnings potential.

A worker's post-injury wage 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 his or her earning capacity up to the pre-injury rate; or
- The worker has, for personal reasons, withdrawn from the workforce; or
- The worker fails to co-operate 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 33(3) which results in payments for total disability being limited to 90% of the maximum and by section 31 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 award can be made under section 23(3) where, following the injury, the worker is earning or is able to earn at or above the maximum wage rate. Where 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, a projected loss of earnings award can be made but only to the extent of the difference between the maximum and the projected earnings.

Although assessment of a permanent partial disability award 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 effective for a given year is the percentage change in that year's maximum wage rate from the year prior, but not less than zero.

When calculating a worker's average net earnings for the purposes of the section 23(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 on the earlier of the first day after the date temporary disability benefits have been payable to the worker

for a cumulative period of 10 weeks; or on the effective date of a worker's permanent disability award.

EFFECTIVE DATE:	April 1, 2018
HISTORY:	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 section 33(7) – (10) of the *Act.*
APPLICATION:	Applies to all decisions made on or after April 1, 2018, including appellate decisions.

#40.14 Provision of Employability Assessments

Workers are provided with a copy of a completed employability assessment before a decision is made on entitlement to a section 23(3) award. 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. Workers are also advised that, at their request, a copy will be made available to their treating physicians. If the details of the employability assessment and its impact on the section 23(3) award are known and agreed to, the 30-day waiting period may be waived.

#40.32 Worsening or Improvement of Disability

If the disability on which an award is based worsens, the extent of the disability is reassessed and a new award is made based on the reassessment. Conversely, if a worker should unexpectedly recover from a disability classified as permanent, the permanent disability award would be subject to termination or downward adjustment.

#41.00 DURATION OF PERMANENT DISABILITY PERIODIC PAYMENTS

Section 23.1 of the *Act* provides:

Compensation payable under section 22(1), 23(1) or (3), 29(1) or 30(1) may be paid to a worker, only

(a) if the worker is less than 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, and

(b) if the worker is 63 years of age or older on the date of injury, until the later of the following:

(i) 2 years after the date of 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.

Section 23.1 of the *Act* provides for the payment of compensation until a worker reaches 65 years of age.

Where the Board is satisfied a worker would retire after reaching 65 years of age, section 23.1 permits the Board to continue to pay benefits to the age the worker would retire after the age of 65 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 (eg. CPP, OAS, employer pension plan, RRSP or other personal savings).

When determining whether a worker would retire after age 65, the circumstances under consideration are those of the individual worker as they existed at the time of injury.

The standard of proof under the *Act* is on a balance of probabilities as described in policy item #97.00, Evidence. However, as age 65 is the established retirement age under the *Act*, the Board requires evidence that is verified by an independent source to confirm the worker would work past age 65. Evidence is also required so that the Board can establish the worker's new retirement date for the purposes of concluding permanent disability award payments.

Examples of the kinds of independent verifiable evidence that may support a worker's statement that he or she would have worked past age 65, and to establish the date of retirement, include the following:

- names of the employer or employers the worker intended to work for after age 65, a description of the type of employment the worker was going to perform, the expected duration of employment, and information from the identified employer or employers to confirm that he or she intended to employ the worker after the worker reached age 65 and that employment was available;
- a statement from a bank or financial institution outlining a financial plan and post age 65 retirement date, established prior to the date of the injury; and

- an accountant's statement verifying a long-term business plan (for self-employed workers) established prior to the date of the injury, indicating continuation of work beyond age 65.

Where the above type of evidence is available, this would be positive evidence in support of a determination that a worker would have worked until after age 65.

The following are examples of other kinds of independent verifiable evidence that alone may not be determinative of whether a worker would retire after reaching 65 years of age:

- information provided from the worker's pre-injury employer, union or professional association regarding the normal retirement age for workers in the same pre-injury occupation and whether there are incentive plans for workers working beyond age 65;

- information from the pre-injury employer about whether the worker was covered under a pension plan provided by the employer, and the terms of that plan;

- information regarding whether the worker would have the physical capacity to perform the work;

- financial obligations of the worker, such as a mortgage or other debts;

- family commitments of the worker; and

- an outstanding lease on a commercial vehicle (for self-employed workers).

These are not conclusive lists of the types of evidence that may be considered. The Board will consider any other relevant information in determining whether a worker would have worked past age 65 and at what date the worker would have retired.

The issue for the Board to determine is whether there is sufficient positive evidence that it is more likely than not that the worker would have retired after age 65. In order to make this determination, the Board considers a worker's statement of intention to retire after age 65 and looks for evidence that is verified by an independent source to support the worker's statement.

Generally the decision as to a worker's retirement date is made as part of the determination of a worker's entitlement to a permanent disability award.

In some circumstances, the decision as to a worker's retirement date may be made prior to the determination of a worker's entitlement to a permanent disability award. For example, when a worker's retirement date impacts a worker's entitlement to temporary disability or vocational rehabilitation benefits.

In these cases, the retirement date on the temporary disability or vocational rehabilitation benefit will also apply to the resulting permanent disability benefit, if awarded.

Where the Board is satisfied that a worker would have continued to work past age 65 if the injury had not occurred, permanent disability award periodic payments may continue past that age until the date the Board has established as the worker's retirement date. At the worker's age 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 a 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 implementation of the permanent disability award, the award is calculated and paid to the date of death. The situation where such a worker would have received a lump sum award is dealt with in policy item #45.00.

EFFECTIVE DATE: June 1, 2014
APPLICATION: Applies to all decisions on or after June 1, 2014

#42.00 PAYMENT OF PERMANENT DISABILITY AWARDS

Permanent disability awards under sections 22 and 23 are normally payable monthly until the worker reaches retirement age as determined by the Board. However, some are paid as lump sums. The cheques are mailed to the worker's home address or, if she or he elects, direct to their bank 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.

#42.10 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 his condition stabilized or was first considered to be permanent.

Where a worker has been paid any temporary disability benefits under section 29 or 30 of the *Act*, the permanent disability periodic payments will take effect from

the date following the termination of these temporary 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. Wage-loss benefits under section 30 would be 90% of the worker's average net earnings in this employment. Should the worker eventually be assessed at a permanent disability award rate which is higher than the rate paid for temporary benefits under section 30, it would appear that the worker may have suffered a loss of compensation income. The *Act*, however, precludes the payment of both temporary and permanent benefits for the same condition at the same time.

A problem of permanent disability award 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 benefits under section 30. 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 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 the award. 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.

When there was no examination by either a Board Medical Advisor or an External Service Provider when wage-loss benefits were terminated under section 30, 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 award will be backdated to the date benefits were terminated under section 30.

EFFECTIVE DATE: June 1, 2009 – Delete references to Board officer.
APPLICATION: Applies on or after June 1, 2009

#42.12 Retroactive Awards

Where a permanent disability award is granted retroactively, the payments due prior to the date of the award 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 an award of $1,000 per month, for the period March 17 to 31 (15 calendar days), the calculation is as follows:

$\frac{\$1,000}{31 \text{ days}}$ x 15 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 award when the worker received wage-loss or rehabilitation benefits. However, no such reduction is made when the award is 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 policy item #50.00.

#42.20 Permanent Disability Award Adjustments

If a permanent disability award to a worker or a dependant is 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 award 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 policy item #113.10.

EFFECTIVE DATE:	March 3, 2003 (as to references to Review Division and Workers' Compensation Appeal Tribunal)
APPLICATION:	Not applicable.

#43.00 DISFIGUREMENT

Section 23(5) of the *Act* provides:

> Where the worker has suffered a serious and permanent disfigurement which the board considers is capable of impairing the worker's earning capacity, a lump sum in compensation may be paid, although the amount the worker was earning before the injury has not been diminished.

#43.10 Requirements for Award

Section 23(5) establishes the following requirements:

1. The disfigurement must be "permanent". A temporary disfigurement is not sufficient.

2. The disfigurement must be "serious". No award 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 has regard to the age and occupation of the worker, the visibility and extent of the disfigurement and any other relevant circumstances. Since section 23(5) states that the amount the worker is currently earning does not have to be diminished, this requirement is concerned with the worker's long-term earning capacity.

Where there is disfigurement as well as a permanent disability, the worker may receive awards for both. Subject to the Board applying section 35(2) of the *Act* (see policy item #45.00), the award for the permanent disability is a periodic payment, and the award for disfigurement a lump sum. These awards must be assessed separately.

Disfigurement is concerned with the appearance of the body, not loss of bodily function. Therefore, a loss of skin function, for example, soreness or itchiness or unusual sensitivity to light, heat or humidity, will be considered for a permanent disability rather than a disfigurement award. The granting of an award will depend on the normal criteria for permanent disability awards.

The ultimate aim of disfigurement and permanent disability awards is to compensate for loss of earning capacity. The worker should not receive double compensation for the same loss. No disfigurement award is granted for something which is directly covered by a permanent disability award, for example, the deformity caused by the normal appearance of an amputated limb. A disfigurement award may be considered where the appearance of an impairment for which a permanent partial disability award has been granted is disfiguring to an exceptional degree.

If the worker receives an award of 100% under section 23(1), or an award for total unemployability under section 23(3), there is no additional loss of earning capacity which can form the basis for a disfigurement award.

Where psychological disability results from disfigurement, consideration will be given to a permanent disability award under section 23(1) or 23(3) following the normal practices for such awards (see Item C3-22.30, *Compensable Consequences – Psychological Impairment*).

#43.20 Amount of Award

In calculating the amount of an award, 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 award 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, 2019 – December 31, 2019

Head and Neck

Class	Maximum Points	Minimum Award for Class ($)	Maximum Award for Class ($)	Dollar Value per point within Class ($)
1	24	0	6,998.16	291.59
2	49	7,278.08	13,996.16	279.92
3	74	15,136.84	42,513.16	1,140.68
4	99	43,646.85	70,855.41	1,133.69

Each Hand

Class	Maximum Points	Minimum Award for Class ($)	Maximum Award for Class ($)	Dollar Value per point within Class ($)
1	24	0	2,274.48	94.77
2	49	2,372.44	4,723.48	97.96
3	74	5,094.38	13,995.98	370.90
4	99	14,380.87	23,618.23	384.89

Each Arm

Class	Maximum Points	Minimum Award for Class ($)	Maximum Award for Class ($)	Dollar Value per point within Class ($)
1	24	0	1,749.60	72.90
2	49	1,819.58	3,499.10	69.98
3	74	3,786.00	10,671.60	286.90
4	99	10,951.52	17,669.60	279.92

Each Leg (including the foot)

Class	Maximum Points	Minimum Award for Class ($)	Maximum Award for Class ($)	Dollar Value per point within Class ($)
1	24	0	1,224.24	51.01
2	49	1,266.24	2,274.24	42.00
3	74	2,463.21	6,998.49	188.97
4	99	7,185.90	11,683.74	187.41

Torso

Class	Maximum Points	Minimum Award for Class ($)	Maximum Award for Class ($)	Dollar Value per point within Class ($)
1	24	0	1,224.24	51.01
2	49	1,266.24	2,274.24	42.00
3	74	2,463.21	6,998.49	188.97
4	99	7,185.90	11,683.74	187.41

The dollar values per point within each class are adjusted on January 1 of each year. The minimum and maximum award for each class are adjusted accordingly. Effective June 30, 2002, the percentage change in the consumer price index determined under section 25.2 of the *Act*, as described in policy item #51.20 will be used.

4. The amount of the award 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 award is $568.62 (6 x $94.77).

5. The amount of the award 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 award 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 award is $1,644.24 [(34 – 24) x $42.00 + $1,224.24].

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 award 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 = $568.62 (6 x $94.77).

Amount awarded is $568.62.

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 award 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 award for a torso disfigurement in the previous Class (Class 1) is $1,644.24 [(34 – 24) x $42.00 + $1,224.24].

Amount awarded is $1,644.24.

EFFECTIVE DATE: June 1, 2009 – Delete reference to Board officer.
HISTORY: May 1, 2008 – Amendments to the formula for determining the amount of disfigurement awards to ensure that disfigurement awards increase uniformly within each class for greater degrees of disfigurement. Applies to all decisions including appellate decisions made on or after May 1, 2008.
APPLICATION: Applies on or after June 1, 2009

#44.00 PROPORTIONATE ENTITLEMENT

Section 5(5) of the *Act* provides:

> Where the personal injury or disease is superimposed on an already existing disability, compensation must be allowed only for the proportion of the disability following the personal injury or disease that may reasonably be attributed to the personal injury or disease. The measure of the disability attributable to the personal injury or disease must, unless it is otherwise shown, be the amount of the difference between the worker's disability before and disability after the occurrence of the personal injury or disease.

This subsection 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.

#44.10 Meaning of Already Existing Disability

The mere fact that the worker suffered from 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 full disability presently suffered by the worker would have resulted in any event, regardless of any pre-existing disability, section 5(5) 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, regard will be had to 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 5(5) should be applied.

Section 5(5) 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 an award 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 awarded by the other agency.

#44.20 Temporary Disability and Health Care Benefits

It is not the policy of the Board to apply the provisions of section 5(5) to health care benefits or temporary disability benefits. Ordinary wage loss will be paid 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 awards.

#44.30 Permanent Disability

Where a worker already has a pre-existing disability, and suffers a work injury resulting in an aggravation of the disability, wage-loss compensation is paid for the period of any temporary total disability. If the aggravation was temporary only and the worker recovers from the aggravation so that she or he is restored to the position of the pre-existing disability, there is then no residual disability resulting from the work injury, and therefore no further compensation. However, where 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 is the compensable aggravation.

Assuming that a pre-existing impairment has been established, section 5(5) requires that compensation shall be allowed only for such proportion of the worker's "disability" as may reasonably be attributable to the personal injury or disease. "Disability" means loss of body function or physical impairment.

The measure of the disability attributable to the personal injury or disease shall, unless it is otherwise shown, be the amount of the difference between the worker's disability before and disability after the occurrence of the personal injury or disease. (10)

The Board's practice in relation to section 5(5) 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 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% disability. If the whole of that disability is attributable to the injury, the monthly permanent disability award granted under section 23(1) 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 5(5) requires that compensation only be awarded 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.

#44.31 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 award is made under section 5(5). If it decides that a portion of the loss is attributable to the pre-existing disability, a permanent disability award is only granted 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 do 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 5(5).

#45.00 LUMP SUMS AND COMMUTATIONS

Section 35(2) of the *Act* provides:

> The Board may in its discretion
>
> (a) commute all or part of the future amounts that are to be set aside for payment of a retirement benefit and the periodic payments due or payable to the worker to one or more lump sum payments, to be applied as directed by the Board; and
>
> (b) divide into periodic payments compensation payable in a lump sum.

In case of death or permanent total disability or in case of permanent partial disability where the impairment of earning capacity exceeds 10% of the worker's earning capacity at the time of the injury, no commutation of periodic payments can be made under subsection (2) except upon the application of and at an amount agreed to by the dependant or worker entitled to such payments. (11)

#45.10 Permanent Disability Periodic Payment Categories/Lump Sum Awards

Category A:

Where

1. a compensable disability has been assessed at not more than 10% of total disability, and

2. the permanent disability periodic payment is not more than $200.00 per month,

a lump sum will be awarded 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 23.2 of the *Act*.

Category B:

> In any case not within Category A, where the permanent disability periodic payment is more than $200.00 per month, the award 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.

Where a worker or dependant has more than one permanent disability award or dependant benefit on one or more claims, the above figures apply to the combined total. Where the worker or dependant has had previous commutations or lump sum awards, these previous awards are not applied to the combined total.

Where a commutation request is made after the granting of a permanent disability award or dependant benefit, the monetary level at the date of the request is used rather than the level at the date of the award.

A review of the monetary level in Categories A and B will be undertaken annually. Any changes to the amount will normally take place on the first day of the month following the month of the review.

#45.20 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 granted awards that fall within Category A will automatically be given a lump sum award.

The general rule is that no commutation will be granted 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 disability award.

4. A commutation will not be allowed where the applicant is a person whom the Board considers incapable of managing his or her own affairs or who has a demonstrated incapacity for money management.

5. Where there is an application by a surviving spouse to commute an award which is paid in whole or part for the children regard may have to be had to the separate interests of the 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 permanent disability award 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 the dependants following his or her death is not a ground on which the Board can permit a commutation.

EFFECTIVE DATE:	March 1, 2007
APPLICATION:	The amendments to this policy, that term commutations are no longer available, brought into effect by BOD Resolution No. 2007/01/23-02, apply to all applications for commutations made on or after March 1, 2007.
HISTORY:	Housekeeping amendments made on November 24, 2011 in accordance with amendments to the *Act*. This policy was amended effective 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 Resolution No. 2002/08/27-04 for details of the amendments. The policy as amended October 1, 2002 applies to all new claims received, all active claims that were awaiting an initial 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. The policy as amended October 1, 2002 does 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.

This policy was created on July 16, 2002 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.

#45.21 Death of Worker Prior to Award under Category A in Policy Item #45.10

Under the terms of the *Act*, disability awards are payable to a worker. There is no provision for a disability award to be payable in respect of a deceased worker.

The *Act* distinguishes between two different categories of benefits:

1. Benefits payable to a disabled worker.

2. Benefits payable to dependants and others in respect of the death of a worker.

No compensation under the first heading can validly be awarded in respect of future disability after the death of a worker. 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. The letter of decision sent by the Board was therefore void, and no payment was due under it.

EFFECTIVE DATE: June 1, 2009 – Delete reference to Disability Awards Officer.

APPLICATION: Applies on or after June 1, 2009

#45.30 Types of Commutations Permitted

Where a partial or full commutation of a permanent disability award 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 award, 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.

EFFECTIVE DATE:	March 1, 2007
APPLICATION:	This policy applies to all applications for commutations made on or after March 1, 2007.
CROSS REFERENCES:	Chapter 18, *Retirement Benefits*

#45.40 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.

#45.41 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 awards if they became aware that commutations could easily be obtained to pay off debts. Section 15 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. Therefore, a commutation is more likely to be allowed for paying off debts that were incurred prior to the injury.

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. It may, in such cases, be more appropriate to refer the worker for financial counselling rather than to attempt to resolve the situation by a commutation of permanent disability periodic payments. Nevertheless, a commutation to pay off debts may be advisable and in the best interests of the worker if it will avoid high interest obligations. Commutation applications for this purpose will be carefully scrutinized for other alternatives before being allowed.

#45.42 Investments

A commutation will not be allowed for investment purposes.

#45.43 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.

EFFECTIVE DATE: June 1, 2009 – Delete reference to Board officer.
APPLICATION: Applies on or after June 1, 2009

#45.44 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.

#45.45 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 policy item #45.41, 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 claimant with current accommodation.

#45.50 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 claimant may properly evaluate the options open.

If the value of a commutation under Category B in policy item #45.10 exceeds the limit set in Category A, prior approval by a Vice-President is required before granting the request. Where an application is received that does not fall within

the guidelines and it is thought that there should be some departure, the application must also be referred to the Vice-President for consideration.

An employer is not normally advised of the granting of a commutation. An exception is made where the employer is the Federal Government. It is advised of the amount and type of the commutation.

EFFECTIVE DATE: June 1, 2009 – Delete references to Board officers, Vocational Rehabilitation Services and Compensation Services Division.

APPLICATION: Applies on or after June 1, 2009

#45.60 Amount Paid on Commutations

When a permanent disability award reserve and a retirement reserve are established or a liability is calculated for an award and a retirement benefit, the monthly payment amount and the periodic future 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 where 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 a permanent disability award commutation is granted, the monthly permanent disability award 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 permanent disability awards 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 permanent disability awards 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 at the surviving dependant’s request.

#45.61 Calculation of Lump-sum Payment or Commutation

Where, as a result of the application of the policies outlined in policy items #45.10 to #45.60, 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:	June 1, 2009 – Delete reference to Board officer.
HISTORY:	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.
APPLICATION:	Applies on or after June 1, 2009

#46.00 REVIEW OF OLD PERMANENT DISABILITY AWARDS UNDER SECTION 24

Section 24(2) of the *Act* provides:

> With respect to a claim for compensation to which this section applies, the Board must, on application by the worker, reconsider the compensation benefits; and, if it decides that, in its opinion, the worker is not receiving adequate compensation having regard to the projected loss of income resulting from the disability, periodic payments must be established or raised accordingly.

EFFECTIVE DATE:	August 1, 2013 – title change and housekeeping amendment.
APPLICATION:	This policy applies to all decisions made on or after August 1, 2013.

#46.01 Claims to Which Section 24 Applies

Section 24(1) provides that

> This section applies to the claims for compensation that the Board may by regulation determine, provided that
>
> (a) the worker is still suffering from a compensable disability sustained more than 10 years before the application under subsection (2); and
>
> (b) a permanent disability award was made by the Board based on a percentage of total disability of 12% or greater, or the case is of a kind in which the Board uses a projected loss of earnings method in calculating compensation.

A regulation has been issued by the Board which is set out below:

1. In this regulation, “Act” means the *Workers Compensation Act*.

2. Section 24 [*reconsidering benefits*] of the *Act* applies to the following claims:

   (a) the worker is still suffering from a compensable disability sustained more than 10 years before the worker's application under section 24(2) of the *Act*, and a permanent disability award was made by the Board based on a percentage of total disability of 12% or greater for that compensable disability;

   (b) the worker is still suffering from a compensable disability sustained more than 10 years before the worker's application under section 24(2) of the *Act*, and a permanent disability award was made by the Board for an injury involving the spinal column;

   (c) the worker is still suffering from a compensable disability sustained more than 10 years before the worker's application under section 24(2) of the *Act*, and a permanent disability award was made 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) is still suffering from 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 24(2) of the *Act*, and

      (ii) is also still suffering from one or more compensable disabilities sustained at any time before the worker's application under section 24(2) of the *Act*, which, when combined with the compensable disability referred to in subparagraph (i), brings the worker's total permanent disability award made by the Board to a percentage of total disability of 12% or greater for the combined compensable disabilities.

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*.

Notwithstanding that a worker suffering a permanent disability has received an award that has been wholly or partly commuted, or an award for a fixed term, the

worker may apply under this section, but he shall be 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. (12)

EFFECTIVE DATE: August 1, 2013 – update policy to mirror section 24 regulation change.

APPLICATION: This policy applies to all decisions made on or after August 1, 2013.

#46.02 Calculation of Benefits under Section 24

Where a worker is under the age of 65 years, compensation is considered adequate for the purposes of this section if it equals 75% of the projected loss of earnings resulting from the disability. (13)

Section 24(4) provides that "Where a worker is 65 years of age or over, compensation is considered adequate for the purposes of this section if it equals 75% of the projected loss of retirement income resulting from the disability."

Where a worker is under the age of 65 years, periodical payments established or raised under this section are subject to readjustment by reference to subsection (4) upon the worker attaining the age of 65 years. (14)

The calculation of benefits is made in the manner the Board determines. (15)

Where a worker is under the age of 65 years, the Board must determine the projected loss of earnings resulting from the 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 BC (see Supplement No. 1, Appendix 5) is used to establish two of the variables; and an age factor is applied to those cases where the disability was suffered 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 claimant's actual pre-injury earnings, limited by the maximum in effect at the time of 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 claimant might have obtained if he had not been injured.

Where a worker is 65 years of age or over, the Board must determine the projected loss of retirement income resulting from the disability. This involves a determination of:

1. The retirement income that the worker would have been likely to be receiving if he or she 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 being considered by a standard formula is the loss of retirement income from earnings by people at and above the age of 65 years. The formula selected is to use a flat rate cash amount per month for each percentage of disability.

Where a worker's pension has been adjusted under section 24 when under the age of 65 years and the worker has now reached that age, the readjustment is done in the following manner:

1. When an adjustment is made to a pension for a worker who is under the age of 65, that adjustment will be diarized for review three months prior to the worker attaining the age of 65.

2. When the matter comes up for review, the file will be considered in accordance with the procedures developed for calculating awards for workers aged 65 or over. For the purpose of this calculation, the original functional award in effect prior to any previous adjustment under section 24, plus applicable cost of listing adjustment as described in policy item #51.00, will be regarded as the permanent disability award in effect at age 65.

3. The term adjustment payable to age 65 will automatically terminate when the worker reaches age 65. The adjustment calculated as per item (2) above will then come into effect. This new pension will

be the higher of the original pension award plus cost of living adjustments as described in policy item #51.00 or the adjusted permanent disability award determined in reference to the calculation for workers aged 65 or over.

The detailed calculation formulae are set out in Appendix 5 to this manual.

#46.03 Maximum and Minimum Periodic Payments under Section 24

Section 31 applies to the calculation of compensation under section 24, but the calculation is not limited by reference to average earnings at the time of injury. (16)

The periodic payments awarded to a worker following a review under this section shall not exceed the maximum that the Board would award to a worker in an occupational category similar to the occupation of the applicant worker before the injury if she or he had, at the effective date of the review under this section, suffered a compensable disability similar to the compensable disability being suffered by the applicant worker. (17)

No decision under this section shall result in periodical payments to any worker being lower than they would if no application had ever been made under this section. (18)

#46.04 Date when New Periodic Payments Commence under Section 24

Where a worker whose disability occurred before January 1, 1965 applies under this section within one year of the earliest date on which becoming eligible to do so, an increase or establishment of benefits under section 24 is effective from September 1, 1975 and, in all other cases, the effective date for the commencement of an increase or establishment of benefits under the section is the date on which the application is received at the Board. (19)

The following table sets out when claimants whose disabilities occurred prior to January 1, 1965 became eligible to apply under section 24.

Injury Occurred On or Before	Date of Commencement of Eligibility
December 31, 1925	August 1, 1975
December 31, 1928	September 1, 1975
December 31, 1932	October 1, 1975
December 31, 1936	December 1, 1975
December 31, 1940	January 1, 1976

December 31, 1944	February 1, 1976
December 31, 1948	April 1, 1976
December 31, 1952	May 1, 1976
December 31, 1956	June 1, 1976
December 31, 1960	July 1, 1976
December 31, 1964	August 1, 1976

#46.05 Reapplication under Section 24

A worker may reapply under this section for reconsideration of his compensation benefits after a further 10 years have elapsed since the last previous application under this section. (20)

#46.10 Reinstatement of Commuted Pensions under Section 26

Section 26(1) of the *Act* provides that "Where periodical payments for permanent disability were awarded by the Board prior to January 1, 1966, and where

(a) the award was for a percentage of total disability of 12% or greater, and the whole of the periodical payments was commuted prior to that date;

(b) a portion of the periodical payments equivalent to 12% of total disability or greater was commuted prior to that date; or

(c) the award was for a percentage of total disability of 12% or greater and was of periodical payments for a fixed term, and where the worker to whom the award had been made is still suffering from the disability, the Board may, on the application of the worker, establish new periodic payments, which are to commence for the month in which the application is received at the Board."

#46.11 Computation of Twelve Per Cent Disability

In determining the percentage of total disability represented by a commutation of periodical payments, the monthly dollar amount of the commutation should be compared with the monthly dollar amount of the periodical payments before the commutation, and multiplied by the percentage of total disability represented by the periodical payments before the commutation.

If the worker has had more than one commutation in respect of the same or different disabilities, the total value of the commutations and the disabilities is taken into account. In this case, all the commutations required to make the 12% must have occurred prior to January 1, 1966.

Consider the following example of a worker injured in 1936 who had two partial commutations, one in 1952 and one in 1955, who applied for reinstatement in September, 1974.

A.	True percentage of total disability awarded (as varied by age and wage factors)	61.20
B.	Monthly wage rate prior to injury	100.00
C.	Life value of pension per month	38.25
D.	Monthly amount of 1952 commutation	6.75
E.	1952 commutation as percentage of whole disability $\left(\frac{D}{C} \times A\right) \frac{6.75}{38.25} \times 61.20$	10.80
F.	Remaining percentage of total disability (A-E)	50.40
G.	Balance of monthly pension (C-D)	31.50
H.	Recalculation of monthly pension following policy item #39.61 $31.50 \times \frac{66\text{-}2/3}{62\text{-}1/2} \times \frac{2{,}000.00}{12 \times 100.00}$	56.00
I.	Monthly amount of 1955 commutation	2.00
J.	1955 commutation as percentage of whole disability $\left(\frac{I}{H} \times F\right) \frac{2.00}{56.00} \times 50.40$	1.80
K.	Total percentage of disability commuted (E + J)	12.60

In past years, the Board varied the assessed percentage of disability according to the earnings and age of the worker. In calculating the percentage of disability commuted for the purposes of section 26, the disability as varied by these factors is used.

#46.12 Purpose of Section 26 Already Achieved

Section 26(5) provides that “This section does not apply where the purpose of the section has been achieved as a result of an application under section 24 or in some other way.”

Therefore, section 26 has no application to a situation where, in the events that have occurred, a worker has not lost the future benefit of any cost of living increases by reason of the commutation. As under section 26, however, such a worker receives future cost of living increases based on what the periodical payments would have been had they not been commuted.

To take an example, suppose a worker was receiving a pension for permanent total disability, and in 1964 arranged with the Board a partial commutation of that pension equivalent to $10.00 a month. If the remaining pension was increased pursuant to subsequent increases in the statutory minimum, it would, in November 1974, be $341.01 less $10.00 per month, i.e. $331.01. The increases in the minimum have exceeded the cost of living increases, and in the result, the worker has not lost any cost of living increases by reason of the commutation. As cost of living adjustments are now made, the worker will continue to receive the cost of living percentage applied to $341.01 so that the pension will continue to be the same as it would have been without the commutation, less the commuted $10.00 per month.

#46.13 Term Pensions

Where the award was for a fixed term that has not expired or been commuted, section 26 applies upon the expiry of the term. (21) The worker must also wait for the expiry of the term if he or she has to combine an expired or commuted pension with the term pension to satisfy the 12% requirement.

Occasionally, a term pension may be converted into a life pension if the worker is found to have an increased entitlement because of a deterioration in the pensionable condition. Section 26 is applicable as soon as the conversion takes place.

#46.14 Rate of New Periodic Payments

Section 26(3) provides that “In order to calculate the rate of new periodic payments to be established under this section, the Board must determine

(a) the monthly payments that would have been payable on January 1, 1966 if the award had been of periodic payments for life and there had been no commutation, or, where the commutation was partial, the additional rate of monthly payments that would have been payable on that date if there had been no commutation; and

(b) the additional amount of monthly payments that would have been payable for the month during which the application is received by way of increases on the amounts calculated under paragraph (a) if those amounts had continued to be due; namely, the total of all increases that would have been

made from January 1, 1966 to and including the last day of the month preceding the date the application is received."

The rate of the new periodical payments is the amount calculated under clause (b). (22)

Consider the following examples:

1. Worker injured in 1938. Term award which expired in 1952. Application under section 26 in February, 1976.

   A. True percentage of total disability awarded (as varied by age and wage factors) — 18.58%

   B. Monthly wage rate prior to injury — $80.00

   C. Life value of permanent disability award per month (23)
   $\frac{18.58}{100}$ (A) x $\frac{62\text{-}1/2}{100}$ x 80.00 (B) — $9.29

   D. Monthly permanent disability award that would have been payable if there had been no term award under provision in policy item #39.61 (section 33(4))
   9.29 (C) x $\frac{66\text{-}2/3}{62\text{-}1/2}$ x $\frac{2{,}000.00}{12 \text{ x } 80.00}$ (B) — $20.64

   E. Provision in #39.62 inapplicable as would result in permanent disability award less than under policy item #39.61

   F. C.P.I. from January 1, 1966 to January 1, 1976, on $20.64 (D)
   76.3452% of $20.64 — $15.75

   G. New monthly periodical payments under section 26 commencing February 1, 1966 — $15.75

2. Claimant injured in December, 1944. Commuted part of permanent partial disability pension in 1950. Application under section 26 in November, 1974.

   A. True percentage of total disability awarded (as varied by age and wage factors) — 40.97%

   B. Monthly wage rate prior to injury — $150.00

C. Life value of pension per month

$$\frac{40.97}{100} \text{ (A) x } \frac{66\text{-}2/3}{100} \text{ x 150.00 (B)}$$

$40.97

D. Monthly amount commuted $14.95

E. Percentage of total disability commuted

$$\frac{14.95}{40.97 \text{ (C)}} \text{ (D) x 40.97 (A)}$$

14.95%

F. Provision in policy item #39.61 inapplicable as injury occurred after March 18, 1943

G. Additional monthly pension that would have been payable had there been no commutation under provision in policy item #39.62

$$\frac{14.95}{100} \text{ (E) x 130.00}$$

$19.44

H. C.P.I. on additional monthly pension (G) from January 1, 1966 to July 1, 1974
49.85% of $19.44 $9.69

I. Additional monthly periodical payments under section 26 commencing November 1, 1974 (to be added to existing pension) $9.69

#46.15 Cost of Living Adjustment After Reinstatement

Cost of living adjustments after the establishment of the new periodical payments are based on the sum of the amounts calculated under clauses (a) and (b) in policy item #46.14. (24) A formula for calculating these adjustments, which applies both in cases of total and partial commutation is set out below.

Where the commutation was partial, so that part of the original award is still subsisting, the residue of the original award may be blended with the reinstated award under section 26. Where the commutation was total, the formula applies to the reinstated award, and where the commutation was partial, it applies to the blend of the residue of the original award with the reinstated award.

The formula is:

1. The amount of pension benefits being paid for the month preceding the cost of living adjustment $

PLUS

2.	The monthly amount of pension that had been commuted	$
	Subtotal	$
3.	The application of the indexing factor described in policy item #51.00 to that subtotal	$
	Second Subtotal	$
	LESS	
4.	The monthly amount of pension that had been commuted	$
	Total	$

The resulting total is the monthly pension that will be applicable after the cost of living adjustment.

#46.16 Commutation of New Periodic Payments

Generally, no commutation will be allowed in respect of the new periodical payments awarded under section 26. However, the Board does have discretion to permit this in unusual cases.

NOTES

(1) See policy item #65.04

(2) See policy item #40.00

(3) S.23(2)

(4) Permanent Disability Evaluation Schedule Appendix 4

~~(5) See policy item #25.10~~**DELETED**

(6) S.23(4); See policy item #34.20

(7) See policy item #37.21

(8) S.33(4)

~~(9) Earnings and Employment Trends, Jan/Feb 2001, BC Stats, Ministry of Finance and Corporate Relations, Province of British Columbia~~**DELETED**

(10) S.5(5)

(11) S.35(3)

(12) S.24(7)

(13) S.24(3)

(14) S.24(5)

(15) S.24(6)

(16) S.24(8)

(17) S.24(9)

(18) S.24(12)

(19) S.24(11)

(20) S.24(10)

(21) S.26(2)

(22) S.26(4)

(23) The 62-1/2% shown in the equation is the percentage of average earnings used in 1938 for calculating compensation, the equivalent of the present 75%

(24) S.26(4)

CHAPTER 7

PROTECTION OF AND DEDUCTIONS FROM BENEFITS

#47.00 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.

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.

#47.10 ACTIONS BY EMPLOYERS

The obligations of an employer to report the occurrence of industrial injuries and diseases to the Board and to refrain from inhibiting a worker from reporting such occurrences to the Board are discussed in policy item #94.00. Set out below are some additional provisions which prevent an employer from directly or indirectly attempting to prevent a worker from exercising his or her right to receive workers' compensation.

#47.11 Agreements to Waive or Forego Benefits

Section 13(1) provides that "A worker may not agree with his or her employer to waive or to forego any benefit to which the worker or the worker's dependants are or may become entitled . . ., and every agreement to that end is void."

This provision 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. Where there is any suggestion that section 13 has been violated, the claim should be referred immediately to a Director.

EFFECTIVE DATE: June 1, 2009 – Delete reference to Compensation Services Department.

APPLICATION: Applies on or after June 1, 2009

#47.20 Contributions from Workers to Employer

Section 14 provides as follows:

> "(1) It is not lawful for an employer, either directly or indirectly, to deduct from the wages of the employer's worker any part of a sum which the employer is or may become liable to pay into the accident fund or otherwise under this Part, or to require or to permit his worker to contribute in any manner toward indemnifying the employer against a liability which the employer has incurred or may incur under this Part.
>
> (2) Every person who contravenes subsection (1) commits an offence . . . and is liable to repay to the worker any sum which has been so deducted from his or her wages or which he or she has been required or permitted to pay in contravention of subsection (1)."

The maximum fine for the offence referred to in subsection (2) is set out in Appendix 6.

#48.00 ASSIGNMENTS, CHARGES OR ATTACHMENTS OF COMPENSATION

Section 15 of the *Act* provides that "A sum payable as compensation or by way of commutation of a periodic payment in respect of it is not capable of being assigned, charged or attached, nor must it pass by operation of law except to a personal representative, and a claim must not be set off against it, except for money advanced by way of financial or other social welfare assistance owing to the Province or to a municipality, or for money owing to the accident fund."

#48.10 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 15 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.

EFFECTIVE DATE: February 1, 2006 (minor editorial amendments)

APPLICATION: Minor editorial amendments made on February 1, 2006 do not affect the application of this policy.

#48.20 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 his or her compensation claim. 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 Provincial Government agency or a municipality 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 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.

In the case of health and welfare plans or similar insurance plans, while the *Act* in section 15 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 Workers' Compensation Board and the insurance company. See also policy item #99.80.

EFFECTIVE DATE: June 1, 2009 – Delete reference to Board officer.
HISTORY: July 13, 2005 – Amendments clarify that restrictions on the attachment and assignment of compensation created by 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.
APPLICATION: Applies on or after June 1, 2009

#48.21 Employment Insurance

The essence of the arrangement between Human Resources and Skills Development Canada and the Board, as reflected in the respective statutes, is that where 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 Human Resources and Skills Development Canada; but that is a matter between the worker and the Commission. There is no provision under the *Workers Compensation Act* for compensation benefits to be withheld because of the receipt of Employment Insurance benefits.

EFFECTIVE DATE:	June 1, 2009 – Update references to Human Resources and Skills Development Canada and the *Employment Insurance Act*.
HISTORY:	July 13, 2005 – Deletion of 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:	Applies on or after June 1, 2009

#48.22 Social Assistance Payments

Deductions from compensation may be made in respect of social assistance payments made to the worker by the Province or by city or municipal Social Welfare Departments.

At one time, social assistance was provided by individual municipalities, but it is now provided exclusively by the Province. The practice is that when a person who may be entitled to compensation is awarded social assistance, the Province 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 the Province.

The rules set out below are followed in respect of assignments of compensation made by a worker to the Province.

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 the Province.

2. In respect of payments of compensation made after receipt of the assignment:

   (a) Wage Loss

   Refunds will only be made to the Province for wage-loss 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 Award Payments

The Province will be refunded up to the monthly value of the permanent disability award payment for concurrent periods. This will usually apply only to retroactive payments. Ongoing assistance, if being paid, will be adjusted by the Province beyond the implementation date of the award.

(c) Permanent Disability Awards: Cash Awards or Commutations

Where a cash award or commutation is granted, the Province will be reimbursed the equivalent amount of the monthly permanent disability award value of the commutation or lump sum payment 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 the Province for that period. This will generally only occur where the cash award or commutation is being paid on a retroactive basis.

(d) Rehabilitation Allowances

The Province has agreed not to request an Assignment of Benefits from rehabilitation allowances paid under section 16 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 the Province is paid off, the Province 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.

EFFECTIVE DATE: February 1, 2006 (minor editorial amendments)
APPLICATION: Minor editorial amendments made on February 1, 2006 do not affect the application of this policy.

#48.23 Requirements to Pay

The Board may receive written notice requiring that benefits owing to a worker be redirected, in whole or in part, to the Federal Receiver General on account of the

worker's debt under the *Income Tax Act* or the *Excise Tax Act*. Such a notice is referred to as a "Requirement to Pay". The Board will comply with Requirements to Pay.

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

#48.30 Worker Not Supporting Dependants

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

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

Where compensation is being diverted under this provision, any 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*.

EFFECTIVE DATE: February 1, 2006 (minor editorial amendments)
HISTORY: Housekeeping changes made on March 1, 2012 in accordance with amendments to the *Act*.
Housekeeping amendments made on November 24, 2011 in accordance with amendments to the *Act*.
February 1, 2006 – Minor editorial amendments made to policy.
APPLICATION: Minor editorial amendments made on February 1, 2006 do not affect the application of this policy.

#48.40 Overpayments/Money Owed to the Board

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

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

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

#48.41 When Does an Overpayment of Compensation Occur?

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

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

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

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

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

#48.42 Recovery Procedures for Overpayments

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

1. The Vocational Rehabilitation Services and 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 garnisheeing wages.

Policy item #50.00 sets out the procedures regarding the crediting of interest to retroactive wage-loss and permanent disability lump-sum payments. In the case of claims overpayments, interest charges only apply to amounts due where the

overpayment is the result of fraud, misrepresentation or the withholding of information by the worker. Interest is not charged on overpayments that result from the correction of an error. The charging of interest on an overpayment must be approved by a Manager or a Director.

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

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

APPLICATION: Not applicable.

#48.43 Recovery of Overpayments on Reopenings or New Claims

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

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

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

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

#48.44 Deduction of Overpayments from Permanent Disability Awards

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

(a) non-payment of the full permanent disability award for a fixed term;
(b) a partial reduction of the permanent disability award for a fixed term;
(c) a partial reduction of the permanent disability award for the duration of a worker's entitlement to a permanent disability award.

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

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

Where an award 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 award 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.

Permanent disability awards are made to workers and pensions are paid to dependants 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.

#48.45 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.

EFFECTIVE DATE: June 1, 2009 – Delete references to Board officers.
APPLICATION: Applies on or after June 1, 2009

#48.46 Reviews and Appeals on Overpayments

A request for a review by the Review Division may be made on the question of whether the 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 benefit entitlements that accrue. The Board will of course still be permitted to exercise discretion as to the amount and the periodic nature of the recovery.

EFFECTIVE DATE: June 1, 2009 – Delete reference to Board officer.
HISTORY: March 3, 2003 – Inclusion of references to the Review Division and the Workers' Compensation Appeal Tribunal.
APPLICATION: Applies on or after June 1, 2009

#48.47 Waiver of Overpayment Recoveries

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

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

> The President 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 a permanent disability award is 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.

EFFECTIVE DATE: June 1, 2009 – Delete reference to Rehabilitation and Compensation Services Division.

APPLICATION: Applies on or after June 1, 2009

#48.48 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 optional protection 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 benefit 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: June 1, 2009 – Delete reference to Compensation Services.

HISTORY: Housekeeping amendments made on November 24, 2011 in accordance with amendments to the *Act.*
March 18, 2003 – Delete the title Manager, Collections, and the substitution of the Board officer in the Finance Division who has been assigned that authority by the President.

APPLICATION: Applies on or after June 1, 2009

#48.50 Payment to Surviving Spouse Free from Debts of Deceased

Any compensation owing or accrued to a worker for a period not exceeding three months before 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. (3)

#49.00 INCAPACITY OF A WORKER

Under section 12 of the *Act*, “A worker under the age of 19 years is sui juris for the purpose of this Part, and no other person has a cause of action or right to compensation for the personal injury or disablement except as expressly provided in this Part.”

An exception is made by section 35(1) of the *Act* which provides in part that “. . . in the case of minors or persons of unsound mind who the board considers are incapable of managing their own affairs, . . .” payments of compensation “. . . may be made to the persons that the board thinks are best qualified in all the circumstances to administer the payments, whether or not the person to whom the payment is made is the legal guardian of the person in respect of whom the payment is being made.”

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.

#49.10 Worker Receiving Custodial Care in Hospital

Section 35(5) provides that “Where a worker is receiving custodial care in a hospital or elsewhere, periodical payments of compensation due to the worker … may be paid to or for the benefit of

(a) the worker to the extent the worker is able to make use of the money for his or her personal needs or is able to manage his or her own affairs; or

(b) any person who is dependent on the worker for support, or in a case of temporary disability of the worker may be

(c) applied to the maintenance of a home to which the worker is likely to return on his or her recovery; or

(d) accumulated by the board for payment to the worker on his or her recovery,

or in a case of permanent disability may be applied toward the cost of the worker's maintenance, but, in that case and where the worker is conscious, there must be paid to, 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, 2018	—	December 31, 2018	$242.52
January 1, 2019	—	December 31, 2019	$248.45

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

“Subsection (5) applies, regardless of the date of the injury.” (4)

#49.11 Meaning of Custodial Care in Hospital or Elsewhere in Section 35(5)

Section 35(5) applies where a 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 98(3) of the *Act* to discontinue the compensation of workers confined to prison. (5)

#49.12 Nature of the Board's Authority under Section 35(5)

Section 35(5) clearly confers a discretionary power on the Board. In exercising this discretion, the Board is free to choose any of the applicable alternatives listed in section 35(5) 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.

This does not mean that, in exercising its discretion under section 35(5), the Board cannot set its own priorities for the application of the various alternatives. The necessity to set guidelines for Board staff in their administration of this section, as a matter of practice, may require that the Board lay down some order of priority. This will appear from the guidelines set out below in relation to the sub-paragraphs of section 35(5).

#49.13 Application of Section 35(5) 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 paragraphs (a) to (d) of section 35(5). Guidelines for applying these alternatives are set out below in paragraphs 1. to 4.

1. Worker able to use money for personal needs or to manage personal affairs.

   The Board may pay the compensation to the "worker to the extent the worker is able to make use of the money for his or her personal needs or is able to manage his or her 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 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 which the worker can use for personal needs and the amount that he or she can manage. A worker may be capable of managing an amount which is 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 temporary disability payments, 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.

   The Board may pay the compensation 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 he or she 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 paid to the dependant had the worker been capable of managing personal affairs.

Where 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 his or her affairs but 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 8(4) of the *Act*. (6)

3. Maintenance of a home.

The Board may apply the worker's compensation payment to the "maintenance of a home to which the worker is likely to return on his 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.

Temporary disability payments may be "accumulated by the board for payment to the worker on his 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.

#49.14 Application of Section 35(5) in Cases of Permanent Disability

In the case of a worker entitled to permanent 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 paragraphs (a) and (b) and the final paragraph of section 35(5).The guidelines for dealing with these cases are set out below.

1. Worker able to use money for personal needs.

   Under paragraph (a) of section 35(5), 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. Where a worker is capable of handling greater sums than required for personal needs, paragraph (a) of section 35(5) authorizes the Board to pay these greater sums 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.

Where 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 policy item #51.20. The amount of this minimum is set out in policy item #49.10. 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 where the worker is conscious, the minimum amount payable for personal needs is the amount set out in policy item #49.10.

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 35(1) of the *Act*.

#49.15 Application of Section 35(5) 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 35(5) would then cease to have any application so that it would be necessary to resume payment of the worker's permanent disability award. 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 35(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 periodical 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.

#49.20 Imprisonment of Worker

This policy deals with the application of section 98(3). In considering the payment of compensation under this policy, regard must be given the individual circumstances of the case.

Section 98(3) of the *Act* provides:

> Despite sections 22(1), 23(1) or (3), 29(1) and 30(1), where it is found that a worker is confined to jail or prison, the Board may cancel, withhold or suspend the payment of compensation for the period it considers advisable. Where compensation is withheld or suspended, the Board may pay the compensation or any portion of it to the worker's spouse or children, or to a trustee appointed by the Board, who must expend it for the benefit of the worker, the worker's spouse or children.

Section 98(3) applies 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 section 98(3), 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 98(3).
>
> 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 98(3).

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 rehabilitation program. One exception, however, applies to a worker who is entitled to a permanent total disability award under section 22(1) who requires 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 29 and 30) 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 children, or to a trustee appointed by the Board to expend for the benefit of the worker, the worker's spouse or children. If not redirected, these benefits are permanently lost during the period of incarceration.

Permanent disability periodic payments based on the loss of function method of assessment (sections 22 and 23(1)) will either continue to be paid or be withheld during the period of incarceration. If withheld, these payments may be paid, in whole or in part, to the worker's spouse or children, or to a trustee appointed by the Board to expend for the payments of the worker, the worker's spouse or children. Payments neither paid to the worker nor redirected will be paid to the worker on release.

Permanent disability periodic payments based on the projected loss of earnings method of assessment (section 23(3)) will be suspended during the period of incarceration. These payments may be paid, in whole or in part, to the worker's spouse or children, or to a trustee appointed by the Board to expend for the payment of the worker, the worker's spouse or children. If not redirected, these payments are permanently lost during the period of incarceration; however, the worker will be entitled, during the period of confinement, to the section 23(1)

award the worker would have been granted had there been no section 23(3) consideration.

Confinement under section 98(3) 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, compensation 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 children prior to the imprisonment. All, or a portion of the compensation, is paid to them or a trustee, the amount depending 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.

#49.30 Payment of Public Trustee and Committee Fees

The Board pays the fees charged to a worker by the Public Trustee or Committee for managing the worker's entire estate when the following conditions are met:

1. The worker is incapable of managing his or her own affairs and the Public Trustee or Committee administers the worker's estate;

2. The worker's incapacity to manage his or her own affairs results from a compensable injury or disease; and

3. The Public Trustee or Committee is appointed to manage the worker's affairs under the *Patients Property Act* or the *Public Trustee Act*, or equivalent statute.

The Board will pay the Public Trustee and Committee fees in accordance with the fee schedule established by the Public Trustee. Fees may include the account review fee paid to the Public Trustee by Committees and the accountant's fees for preparing the account summaries.

The Board will pay the Committee fees after the Public Trustee has approved the accounts.

#50.00 INTEREST

With respect to compensation matters, the *Act* provides express entitlement to interest only in the situations covered by sections 19(2)(c) and 258. In these situations, the Board will pay interest as provided for in the *Act* (see Item C8-61.10 and policy item #100.83).

In all cases where a decision to award 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 policy item #48.42.

EFFECTIVE DATE: January 1, 2014

HISTORY: By Board of Directors resolution 2015/11/25-01, the application statement of this policy was revised on November 25, 2015.
January 1, 2014 – Policy changes to reflect the removal of the blatant Board error test were made effective January 1, 2014.
June 1, 2009 – Delete references to Board officers.
March 1, 2006 – Amendments to provide for the payment of interest to the dependants of deceased workers in respect of retroactive 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 made on or after January 1, 2014 except where retroactive benefits under sections 17, 22, 23, 29 or 30 of the *Workers Compensation Act* have already been awarded and the initial adjudication on the question of entitlement to interest had been deferred prior to January 1, 2014.

#51.00 COST OF LIVING ADJUSTMENTS TO PERIODIC PAYMENTS

Sections 25(1) and (2) of the *Act* provide the method for indexing periodic payments of compensation to a worker. The sections provide:

(1) For the purposes of this section, the Board must, as of January 1 of each year,

(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, as published by Statistics Canada, and

(b) subtract 1% from the percentage change determined under paragraph (a).

(2) The percentage resulting from calculations made under subsection (1) must not be greater than 4% or less than 0%.

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.
- One percentage point is subtracted from the percentage change between these two consumer price indexes.
- If the percentage that results from this subtraction is greater than 4%, it is reduced to 4%. If the percentage that results from this subtraction is less than 0%, no adjustment to periodic payments of compensation is made.

The resulting percentage changes determined annually are set out below:

Date	Percentage
January 1, 2019	1.444614

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

The resulting percentage change is applied on January 1 of each year to periodic payments of compensation made continuously 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, the Board adjusts 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 he or she had been continuously paid since the date of injury or death.

Compensation paid to a worker on or after June 30, 2002 will be indexed according to section 25 of the *Act*, irrespective of the date the worker was injured. However, if the Board pays to a worker, who was injured before June 30, 2002, compensation as a result of a retroactive adjustment, the indexing rules in section 25 of the *Act*, 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 25 of the *Act*.

Effective December 31, 2003, compensation paid to a dependant of a deceased worker is indexed under section 25 of the *Act* 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 *Act*, 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 25 of the *Act*.

Authority to approve adjustments under section 25 has been assigned to the President.

Effective Date: December 31, 2003 (as to references to benefits paid to surviving dependents).

Application: This policy item applies to all periodic payments made to workers and surviving dependants.

#51.20 Dollar Amounts in the *Act*

Section 25.2 (1) of the *Act* provides:

> Subject to subsection (3), 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, as published by Statistics Canada.

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, 2019	2.444614

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.

These provisions do not apply to the figures referred to in policy item #39.61, the maximum wage rate and other figures referred to in policy item #69.00.

Authority to approve adjustments under section 25.2 has been assigned to the President.

Authority has also been assigned to the President to adjust the following amounts to reflect changes based upon the consumer price index, using the formula set out in the applicable item of the *Manual*:

Maximum and Minimum Disfigurement Amount	#43.20
Clothing Allowances	C10-82.00
Additional Benefits for Severely Disabled Workers	C10-84.00
Transportation Allowance	C10-83.00
Subsistence Allowances	C10-83.10
Transfer of Costs	#114.11
Funeral and Other Death Expenses	C8-54.00

The Board adjusts dollar amounts referred to in sections 17 and 18 of the *Act* in accordance with section 25.2 of the *Act*. In addition, effective December 31, 2003, the Board adjusts the dollar amounts referred to in sections 17 and 18 and Schedule C of the *Act*, as it read immediately before June 30, 2002, in accordance with section 25.2 of the *Act*.

EFFECTIVE DATE: December 31, 2003 (as to references to sections 17 and 18 of the *Act* as well as dollar amounts in sections 17 and 18 and Schedule C of the *Act* as it read immediately before June 30, 2002).

HISTORY:	Consequential amendments arising from changes to Chapter 10, *Medical Assistance, Rehabilitation Services and Claims Manual*, were made effective January 1, 2015.
APPLICATION:	This policy item applies to all dollar amounts in the *Act*.

NOTES

(1) S.98(4)

(2) Item AP1-15-1 of the *Assessment Manual*

(3) S.35(4)

(4) S.35(6)

(5) Policy item #49.20

(6) Policy item #48.30

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 5(1):

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

Section 6(1):

> Where
>
> (a) a worker suffers from an occupational disease and is thereby disabled from earning full wages at the work at which the worker was employed or the death of a worker is caused by an occupational disease; and
>
> (b) the disease is due to the nature of any employment in which the worker was employed, whether under one or more employments,
>
> compensation is payable under this Part as if the disease were a personal injury arising out of and in the course of that employment. A health care benefit may be paid although the worker is not disabled from earning full wages at the work at which he or she was employed.

POLICY

Compensation is payable under the *Act* where the death of a worker arises out of and in the course of 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 surviving dependants or in some cases to non-dependent relatives having a reasonable expectation of pecuniary benefit from the continuation of the life of the deceased.

Benefits are 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 award dies as a result of the compensable disability and dependant's benefits are payable, no cost of living adjustment is applied in the 12 month period following the date of death.

PRACTICE

For any relevant PRACTICE information, readers should consult the Rehabilitation and Compensation Services Division's Practice Directives available on the WCB website.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Sections 5(1) and 6(1) of the *Act*.
CROSS REFERENCES:	Average Earnings (Chapter 9), Cost of Living Adjustments to Periodic Payments (policy item #51.00) and Dollar Amounts in the *Act* (policy item #51.20) of the *Rehabilitation Services & Claims Manual,* Volume II
HISTORY:	Replaces 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:

> "dependant" means a member of the family of a worker who was wholly or partly dependent on the worker's earnings at the time of the worker's death, or who but for the incapacity due to the accident would have been so dependent, and, except in section 17(3)(a) to (h), (9) and (13), includes a spouse, parent or child who satisfies the Board that he or she had a reasonable expectation of pecuniary benefit from the continuation of the life of the deceased worker.
>
> "member of family" means
>
> (a) a spouse, parent, grandparent, stepparent, child, grandchild, stepchild, sibling or half sibling, and
>
> (b) a person who stood in the place of a parent to the worker or to whom the worker stood in place of a parent, whether related to the worker by blood or not.

Section 17(7):

> Where 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.

Section 17(8):

> Where 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.

POLICY

1. Meaning of Dependant

The term "dependant" means a member of a worker's family who was wholly or partly dependent on the worker's earnings at the time of the worker's death, or who but for the incapacity due to the accident would have been so dependent. In certain limited situations, as discussed in Item C8-56.70, the term also includes a spouse, parent or child who satisfies the Board that he or she had a reasonable expectation of pecuniary benefit from the worker if the worker had not died.

Section 1 of the *Act* defines who are the members of a worker's family.

Only the members of a worker's family may be found to be the worker's dependants. Thus, a former spouse does not qualify as a dependant of a deceased worker because he or she is not considered a member of the worker's family under the *Act*.

Dependency does not exist simply because the claimant is a member of the worker's family. 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

Where 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.

Where 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.

PRACTICE

For any relevant PRACTICE information, please consult the WorkSafeBC website at worksafebc.com.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Sections 1, 17(7) and 17(8) 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.*
HISTORY:	Housekeeping changes made on March 1, 2012, in accordance with amendments to the *Act*. Housekeeping amendments made on November 24, 2011, in accordance with amendments to the *Act*. Replaces policy items #54.00 and #54.10 of the *Rehabilitation Services & Claims Manual,* Volume II. A typographical correction was made on March 22, 2004.
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:

"spouse" means a person who

(a) is married to another person, or

(b) has lived with another person in a marriage-like relationship for a period of at least

(i) 2 years, or

(ii) if the person has had a child with the other person, 1 year;

"surviving spouse" means a person who was a spouse of a worker when the worker died.

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 a period of at least

(i) 2 years, or

(ii) if the person has had a child with the other person, 1 year.

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 he or she 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 he or she died. A surviving spouse may be a married spouse or a common law spouse of a worker.

PRACTICE

For any relevant PRACTICE information, please consult the WorkSafeBC website at worksafebc.com.

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 – Surviving 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*.
HISTORY:	New Item consequential to Bill 16, the *Family Law Act*, which introduced definitions of spouse and surviving spouse to 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:

"member of family" means

(a) a spouse, parent, grandparent, stepparent, child, grandchild, stepchild, sibling or half sibling, and

(b) a person who stood in the place of a parent to the worker or to whom the worker stood in place of a parent, whether related to the worker by blood or not.

"surviving spouse" means a person who was a spouse of a worker when the worker died.

"invalid" means physically or mentally incapable of earning.

"invalid child" includes a child who, though not an invalid at the date of death of the worker, becomes an invalid before otherwise ceasing to be entitled to compensation.

Section 17(1):

"child" means

(a) a child under the age of 19 years, including a child of the deceased worker yet unborn;

(b) an invalid child of any age; and

(c) a child under the age of 25 years who is regularly attending an academic, technical or vocational place of education,

and "children" has a similar meaning.

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 three following requirements. He or she must be

(a) a child under the age of 19 years, including a child of the deceased worker yet unborn;

(b) an invalid child of any age; or

(c) a child under the age of 25 years who is regularly attending an academic, technical or vocational place of education.

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 17 of the *Act*, a "child" includes a child of the deceased worker yet unborn. To be considered an unborn child of the deceased worker, the child must have been conceived before the worker's death. Where 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*.

Benefits payable in respect of an unborn child of a deceased worker commence 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 benefits will be adjusted when the child is born according to the Canada Pension Plan benefits then being received.

4. Invalid Children

The term "invalid" is defined in the *Act* as "physically or mentally incapable of earning". This means the person is not physically or mentally capable of independently supporting himself or herself financially. A person who has a physical or mental disability, but is capable of independently supporting himself or herself financially is not an "invalid". A temporary physical or mental incapacity to earn is not sufficient to determine that a person is an "invalid".

An "invalid child" includes a child who, though not an invalid at the date of death of the worker, becomes an invalid before otherwise ceasing to be entitled to compensation.

5. Regularly Attending an Academic, Technical or Vocational Place of Education

This Item applies to a child who has reached the age of 19 years but is under the age of 25 years 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 he or she was "regularly attending" a place of education.

Correspondence courses taken at home are not sufficient. The only possible exception might be where 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 age 19, the surviving spouse and/or the child are contacted with regard to plans for continuing education. If the child plans to continue his or her education, the child is advised that benefits will be paid until age 25, including summer months, as long as the child pursues his or her education.

Temporary absences from school will not cause a discontinuation of benefits 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.

PRACTICE

For any relevant PRACTICE information, please consult the WorkSafeBC website at worksafebc.com.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	Sections 1 and 17(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 – Surviving Spouse with Children*; Item C8-56.40, *Compensation on the Death of a Worker – Calculation of Compensation – Children*.
HISTORY:	Housekeeping amendments made on November 24, 2011 in accordance with amendments to the *Act.* Replaces 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 survivor benefits payable to them.

2. The Act

Section 17(1):

> "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 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.

PRACTICE

For any relevant PRACTICE information, please consult the WorkSafeBC website at worksafebc.com.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	Section 17(1) of the *Act*.
CROSS REFERENCES:	Item C8-56.00, *Compensation on the Death of a Worker – Calculation of Compensation – Surviving Spouse with Children*; Item C8-56.20, *Compensation on the Death of a Worker – Calculation of Compensation – Surviving Spouse with No Children*; Item C8-56.40, *Compensation on the Death of a Worker – Calculation of Compensation – Children*.
HISTORY:	Replaces 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 17(2):

> Where compensation is payable as the result of the death of a worker or as the result of injury resulting in death,
>
> (a) in addition to any other compensation payable under this section, an amount in respect of funeral and related expenses, as determined in accordance with the policies of the board of directors, must be paid out of the accident fund,
>
> (b) the employer of the worker must bear the cost of transporting the body to the nearest business premises where funeral services are provided, and
>
> (c) if burial does not take place there, the costs of any additional transportation, up to a maximum determined in accordance with the policies of the board of directors, may be paid out of the accident fund.

Section 17(2.1):

> No action for an amount larger than that established by subsection (2) lies in respect of the funeral, burial or cremation of the worker or cemetery charges in connection with it.

POLICY

1. Funeral and Other Death Expenses

Where compensation is payable as the result of the death of a worker or as the result of injury resulting in death, an amount for funeral and related expenses is paid in addition to any other compensation payable. 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 there any additional transportation may, up to the sum set out below, be paid by the Board.

	Funeral And Related Expenses	Transportation of Body
January 1, 2018 – December 31, 2018	$9,268.72	$1,464.39
January 1, 2019 – December 31, 2019	$9,495.30	$1,500.19

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 25.2 of the *Act*, as described in policy item #51.20, is used.

No action for an amount larger than that established by the above provisions lies in respect of the funeral, burial, or cremation of the worker or cemetery charges in connection with it.

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.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Section 17(2) of the *Act*
CROSS REFERENCES:	Dollar Amounts in the *Act* (policy item #51.20) of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	Replaces 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 eligible surviving spouses, common law spouses or foster parents.

2. The Act

Section 17(13):

> In addition to any other compensation provided, a dependent surviving spouse, common law spouse or foster parent in Canada to whom compensation is payable is entitled to a lump sum of $2,804.44.

POLICY

Lump Sum Payment

A dependent surviving spouse, common law 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, 2018	—	December 31, 2018	$2,737.52
January 1, 2019	—	December 31, 2019	$2,804.44

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

Payment of this amount is made as soon as the claim is accepted.

PRACTICE

For any relevant PRACTICE information, please consult the WorkSafeBC website at worksafebc.com.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Section 17(13) of the *Act*.
CROSS REFERENCES:	Policy item #51.20, *Dollar Amounts in the Act*.
HISTORY:	Housekeeping amendments made on November 24, 2011 in accordance with amendments to the *Act*. Replaces 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 – Surviving 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 surviving spouse with dependent children.

2. The Act

Section 1:

> "surviving spouse" means a person who was a spouse of a worker when the worker died.

Section 17:

(3) Where compensation is payable as the result of the death of a worker or of injury resulting in such death, compensation must be paid to the dependants of the deceased worker as follows:

(a) where the dependants are a surviving spouse and 2 or more children, a monthly payment of a sum that, when combined with 50% of the federal benefits payable to or for those dependants, would equal the total of

(i) the monthly rate of compensation under this Part that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability, subject to the minimum set out in paragraph (g); and

(ii) $364.42 per month for each child beyond 2 in number.

(b) where the dependants are a surviving spouse and one child, a monthly payment of a sum that, when combined with 50% of the federal benefits payable to or for those dependants, would equal 85% of the monthly rate compensation under this Part that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability, subject to the minimum set out in paragraph (g).

(g) the minimum allowances payable under paragraphs (a), (b) and (f) must be the allowances that would be payable if the allowances were calculated under those paragraphs in respect of a deceased worker with average earnings of $39,261.04 per annum.

POLICY

This Item applies to a surviving spouse and children who were wholly or partly dependent on a worker's earnings at the time of the worker's death. A surviving spouse and children who were not dependent upon the worker's earnings may be entitled to compensation under Item C8-56.70.

1. Calculation of Compensation – Surviving Spouse with Two or More Children

The monthly payment for a dependent surviving spouse and two or more dependent children is calculated as follows:

(I) The Board adds:

(a) 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, and

(b) the following amount per month for each child beyond two in number.

January 1, 2018	—	December 31, 2018	$355.72
January 1, 2019	—	December 31, 2019	$364.42

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

(II) The Board then deducts 50% of the federal benefits payable to or for the dependants from the sum determined above.

The example below describes the monthly benefits that would be payable for a dependent surviving spouse and three dependent children following the death of a worker on June 30, 2002. The worker's average net earnings were $40,000 per year.

A.	50% of total federal benefits			
	Federal benefits for surviving spouse		=	437.99
	Federal benefits for children	(3 x 183.77)	=	551.31
	Total federal benefits (surviving spouse and children)		=	989.30
	50% of total federal benefits	50% x 989.30	=	494.65
B.	Monthly permanent total disability award rate at date of death	90% x $\frac{40,000}{12}$	=	3,000
C.	Additional child allowance under section 17		=	263.70
D.	Total monthly benefits (B plus C)		=	3,263.70
	Total benefit entitlement (W.C.B. and federal benefits)		=	3,263.70
E.	Total W.C.B. monthly benefits payable (D less A)		=	2,769.05

2. Calculation of Compensation – Surviving Spouse with One Child

The monthly payment for a dependent surviving spouse with one dependent child is calculated as the difference between:

(a) 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, and

(b) 50% of the federal benefits payable to or for the dependants.

In the example described in section (1) above, monthly benefits would be payable to a dependent surviving spouse and one dependent child as follows:

A.	50% of total federal benefits			
	Federal benefits for surviving spouse		=	437.99
	Federal benefits for child		=	183.77
	Total federal benefits		=	621.76
	50% of total federal benefits	50% x 621.76	=	310.88
B.	Monthly permanent total disability award rate at date of death	90% x $\frac{40,000}{12}$	=	3,000
C.	85% of permanent total disability award rate	85% x 3,000	=	2,550
	Total benefit entitlement (W.C.B. and federal benefits)		=	2,550
D.	Total W.C.B. monthly benefits payable (C less A)		=	2,239.12

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 Benefits

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, 2018	—	December 31, 2018	$38,324.16
January 1, 2019	—	December 31, 2019	$39,261.04

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

5. Commencement of Benefits

Benefits under this Item commence on the day after the date of the worker's death.

6. Duration and Recalculation of Benefits

Compensation for a dependent surviving spouse is payable for life.

Benefits for a dependent surviving spouse with children are 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.

Benefits for dependent children are recalculated under Item C8-57.00 if the surviving 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.

PRACTICE

For any relevant PRACTICE information, please consult the WorkSafeBC website at worksafebc.com.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	Sections (17)(3)(a), (b) and (g) 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*.
HISTORY:	Housekeeping amendments made on November 24, 2011 in accordance with amendments to the *Act*. Replaces 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 – Surviving 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 surviving spouse with no dependent children.

2. The Act

Section 1:

> "surviving spouse" means a person who was a spouse of a worker when the worker died.
>
> "invalid" means physically or mentally incapable of earning.

Section 17:

> (3) Where compensation is payable as the result of the death of a worker or of injury resulting in such death, compensation must be paid to the dependants of the deceased worker as follows:
>
> (c) where the dependant is a surviving spouse who, at the date of death of the worker, is 50 years of age or over, or is an invalid spouse, a monthly payment of a sum that, when combined with 50% of the federal benefits payable to or for that dependant, would equal 60% of the monthly rate of compensation under this Part that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability, but the monthly payments must not be less than $1,177.65.
>
> (d) where the dependant, at the date of death of the worker, is a surviving spouse who is not an invalid and is under the age of 50 years, and there are no dependent children, a monthly payment of a sum that, when combined with 50% of the federal benefits payable to or for that dependant, would equal the product of
>
> (i) the percentage determined by subtracting 1% from 60% for each year that the age of that dependant, at the date of the death of the worker, is under 50 years, and

(ii) the monthly rate of compensation under this Part that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability,

but the percentage determined under subpargraph (i) must not be less than 30% and the monthly payments must not be less than $1,177.65.

(6) Where at the date of death a spouse is not an invalid, but is suffering from 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 spouse a proportion of the compensation that would have been payable if the spouse had been an invalid.

POLICY

This Item applies where there are no dependent children, but there is a surviving spouse who was wholly or partly dependent upon a worker's earnings at the time of the worker's death. A surviving spouse who was not dependent upon the worker's earnings may be entitled under Item C8-56.70.

1. Meaning of "Invalid"

The term "invalid" is defined in the *Act* as "physically or mentally incapable of earning". This means the person is not capable of independently supporting himself or herself financially. A person who has a physical or mental disability, but is capable of independently supporting himself or herself financially is not an "invalid". A temporary physical or mental incapacity to earn is not sufficient to determine that a person is an "invalid".

Where at the date of death a spouse is not an invalid, but is suffering from 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 spouse a proportion of the compensation that would have been payable if the spouse had been an invalid.

2. Calculation of Compensation – Surviving Spouse 50 Years or Older or Invalid

The monthly payment for a surviving spouse who, at the date of the worker's death, is either:

- 50 years of age or over, or
- an invalid,

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 death, sustained a permanent total disability, and

(b) 50% of the federal benefits payable to or for the surviving spouse.

The monthly payment is subject to the minimum amount provided in section 5 of this Item.

3. Calculation of Compensation – Surviving Spouse under 50 Years

The monthly payment for a surviving spouse who, at the date of the worker's death, is not an invalid and is under the age of 50 years 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 surviving spouse, at the date of the worker's death, is under 50 years, and

(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 50% of the federal benefits payable to or for the surviving 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 surviving spouse to the nearest whole number. For instance, a surviving spouse who is 35 years and 11 months is considered 35, not 36, for the purpose of determining the percentage to use in establishing benefits.

The example below describes the monthly benefits that would be payable for a dependent surviving spouse who, at the date of the worker's death, has no children and is 35 years old. The worker, whose death occurred on June 30, 2002, had average net earnings of $40,000 per year.

A.	50% of federal benefits			
	Federal benefits for surviving spouse		=	437.99
	50% of federal benefits	50% x 437.99	=	219
B.	Determination of percentage based on the surviving spouse's age	50 - 35	=	15%
	Relevant percentage	60% - 15%	=	45%
C.	Monthly permanent total disability award rate at date of death	90% x $\frac{40,000}{12}$	=	3,000
D.	45% of permanent total disability award rate	45% x 3,000	=	1,350
	Total benefit entitlement (W.C.B. and federal benefits)		=	1,350
E.	Total W.C.B. monthly benefits payable (D less A)		=	1,131

4. Change in Federal Benefits

If the Board receives evidence of a change in the entitlement of a dependent surviving 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 Benefits

The minimum monthly payment for a dependent surviving spouse under this Item is as follows:

January 1, 2018	—	December 31, 2018	$1,149.55
January 1, 2019	—	December 31, 2019	$1,177.65

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 Benefits

Benefits under this Item commence on the day after the date of the worker's death.

7. Duration and Recalculation of Benefits

Compensation for a dependent surviving spouse is payable for life.

The amount of compensation payable for a dependent surviving spouse who is an invalid is recalculated in accordance with Item C8-57.00 if the surviving spouse ceases to be an invalid.

PRACTICE

For any relevant PRACTICE information, please consult the WorkSafeBC website at worksafebc.com.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	Section 1 and sections 17(3)(c) and (d) 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*.
HISTORY:	Housekeeping amendments made on November 24, 2011 in accordance with amendments to the *Act*. Replaces 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 dependent separated spouse and any dependent children living with that spouse.

2. The Act

Section 17:

(9) Where compensation is payable as the result of the death of a worker, or of injury resulting in death, and where at the date of death the worker and dependent spouse were living separate and apart, and

(a) there was in force at the date of death a court order or separation agreement providing periodic payments for support of the dependent spouse, or children living with that spouse, no compensation under subsection (3) is payable to the spouse or children living with the spouse; but monthly payments must be made in respect of that spouse and those children equal to the periodic payments due under the order or agreement; or

(b) there was no court order or separation agreement in force at the date of death providing periodic payments for support of the dependent spouse, or children living with that spouse, and

(i) the worker and dependent spouse were living separate and apart for a period of less than 3 months preceding the date of death of the worker, compensation is payable as provided in subsection (3); or

(ii) the worker and dependent spouse were separated with the intention of living separate and apart for a period of 3 months or longer preceding the death of the worker, monthly payments must be made up to the level of support which the Board believes the spouse and those children would have been likely to receive from the worker if the death had not occurred.

(10) Compensation payable under subsection (9) must never exceed the compensation that would have been payable under subsection (3) 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 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 benefits under another Item in this chapter.

1. Calculation of Compensation – Court Order or Separation Agreement

Where, at the date of the worker's death, a court order or separation agreement was in force providing periodic support payments for the dependent spouse, or children living with that spouse, monthly benefits equal the payments due under that order or agreement.

Section 17(10) of the *Act* provides that compensation must never exceed the amount 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 award than would be otherwise payable under section 17(3) of the *Act* if there had been no separation.

It is irrelevant whether the worker was actually meeting his or her obligations under the court order or separation agreement at the date of death. However, where the worker was in arrears of support payments at the date of death, benefits will not cover the amount in arrears.

2. Calculation of Compensation – No Court Order or Separation Agreement

Where, at the date of the worker's death, there was no court order or separation agreement in force providing support payments for the 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 Less than Three Months – No Court Order or Separation Agreement

Where, at the date of death, the worker and spouse had been living separate and apart for less than three months, benefits are calculated under section 17(3) of the *Act* as if there had been no separation.

2.2 Separation of More than Three Months – No Court Order or Separation Agreement

Where, at the date of death, the worker and 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 2.2.1 of this Item.

Where it is found that, at the date of death, the parties did not intend to live separate and apart, section 17(9) of the *Act* does not apply and monthly benefits are calculated as if there had been no separation.

Where it is found that, at the date of death, the parties did intend to live separate and apart, monthly benefits are based on the amount that the Board believes the dependent spouse and children would likely have received from the worker if the worker had not died. However, compensation must never exceed the amount that would have been payable under section 17(3) of the *Act* if there had been no separation.

2.2.1 Determination of Intention to Live 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.

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 benefits under this Item.

4. Commencement of Benefits

Benefits under this Item commence on the day after the date of the worker's death.

5. Duration of Benefits

Benefits for a separated 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, benefits for a separated spouse under this Item are for life, unless the Board determines the worker would have provided payments for a lesser period of time.

PRACTICE

For any relevant PRACTICE information, please consult the WorkSafeBC website at worksafebc.com.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	Sections 17(9) and (10) 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 – Surviving Spouse with*

	Children; Item C8-56.10, *Compensation on the Death of a Worker – Calculation of Compensation – Surviving Spouse with No Children*; Item C8-56.40, *Compensation on the Death of a Worker – Calculation of Compensation – Children*; Item C8-56.30, *Compensation on the Death of a Worker – Calculation of Compensation – Common Law Relationships*; Item C8-56.70, *Compensation on the Death of a Worker – Calculation of Compensation – Persons with a Reasonable Expectation of Pecuniary Benefit*.
HISTORY:	Replaces 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 surviving spouse who was a common law spouse of the worker at the time the worker died.

2. The Act

Section 1:

"spouse" means a person who

(a) is married to another person, or

(b) has lived with another person in a marriage-like relationship for a period of at least

(i) 2 years, or

(ii) if the person has had a child with the other person, 1 year;

"surviving spouse" means a person who was a spouse of a worker when the worker died.

Section 17:

(11) Compensation under this section is payable to a surviving spouse described in paragraph (b) of the definition of "spouse" only if the worker was living with and contributing to the support and maintenance of the spouse immediately prior to the worker's death.

(12) If

(a) a worker has left both

(i) a dependent surviving spouse described in paragraph (a) of the definition of "spouse" from whom, at the time of death, the worker was living separate and apart, and

(ii) a surviving spouse described in paragraph (b) of the definition of "spouse", and

(b) there is a difference in the amount of compensation

(i) payable to the spouse referred to in paragraph (a)(i) of this section by reason of the separation, and

(ii) that would have been payable to that person if that person 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 described in paragraph (a)(ii) of this subsection.

POLICY

1. Compensation Payable to a Common Law Surviving Spouse

Compensation under this Item is payable to a common law surviving spouse only if the worker was living with and contributing to the support and maintenance of the common law surviving spouse immediately prior to the worker's death.

The amount of compensation that may be payable to a common law surviving spouse is dependent on the existence of a married surviving spouse, from whom the worker was living separate and apart at his or her date of death.

Where, a worker left both:

(a) a dependent married surviving spouse from whom, at the date of death, the worker was living separate and apart; and

(b) a common law surviving spouse, whom the worker was living with, and contributing to the support of, immediately prior to his or her death; and

(c) there is a difference in the amount of compensation payable to the married surviving 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 person, if that person and the worker had not been living separate and apart, then

the Board may pay compensation to the common law surviving spouse, up to the amount of the difference.

2. Commencement of Benefits

Benefits under this Item commence on the day after the date of the worker's death.

3. Duration of Benefits

Compensation for a common law surviving spouse is payable for life. Benefits are not affected if the common law surviving spouse remarries.

PRACTICE

For any relevant PRACTICE information, please consult the WorkSafeBC website at worksafebc.com.

EFFECTIVE DATE:	March 1, 2012
AUTHORITY:	Sections 17(11) and (12) 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 – Surviving Spouse with Children*; C8-56.10, *Compensation on the Death of a Worker – Calculation of Compensation – Surviving 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*.
HISTORY:	This Item was amended on March 1, 2012 to update sections 17(11) and 17(12), and to make other amendments in accordance with changes to the *Act*, arising from Bill 16, the *Family Law Act*.

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.
Housekeeping amendments made on November 24, 2011 in accordance with amendments to the *Act*.
Replaces 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:

> "surviving spouse" means a person who was a spouse of a worker when the worker died.

Section 17:

> (3) Where compensation is payable as the result of the death of a worker or of injury resulting in such death, compensation must be paid to the dependants of the deceased worker as follows:
>
> (f) where there is no surviving spouse eligible for monthly payments under this section, and
>
> (i) the dependant is a child, a monthly payment of a sum 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 that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability;
>
> (ii) the dependants are 2 children, a monthly payment of a sum 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 that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability; or
>
> (iii) the dependants are 3 or more children, a monthly payment of a sum 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 that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability; and

(B) $364.42 per month for each child beyond 3 in number,

subject, in all cases, to the minimum set out in paragraph (g).

(g) the minimum allowances payable under paragraphs (a), (b) and (f) must be the allowances that would be payable if the allowances were calculated under those paragraphs in respect of a deceased worker with average earnings of $39,261.04 per annum.

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 Surviving Spouse

Where there is a surviving spouse eligible for periodic benefits, the children's benefits are calculated in conjunction with those of the surviving spouse under Items C8-56.00, C8-56.20 or C8-56.30. With one exception, this is so whether the children live with the surviving spouse or not. Where they live apart, the apportionment provisions described in Item C8-58.00 may be applied to the benefits. The exception involves item C8-56.20, which applies to children only when they are living with the separated spouse at the date of the worker's death.

Where there is a surviving spouse and a child or children, and the surviving spouse subsequently dies, benefits for the dependent children are recalculated under Item C8-57.00.

2. Calculation of Compensation – Where there is no Surviving Spouse

Where there is no surviving spouse or common law spouse eligible for monthly payments under section 17 of the *Act*, benefits for any dependent children are calculated as described below.

2.1 One Dependent Child

The monthly payment for one dependent child 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 Dependent Children

The monthly payment for two dependent children 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 Three or More Dependent Children

The monthly payment for three or more dependent children 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) the following amount per month for each child beyond three in number:

January 1, 2018	—	December 31, 2018	$355.72
January 1, 2019	—	December 31, 2019	$364.42

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

(II) The Board then deducts 50% of the federal benefits payable to or for those children from the sum determined above.

3. Change in Federal Benefits

If the Board receives evidence of a change in a dependant child'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 Benefits

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, 2018	—	December 31, 2018	$38,324.16
January 1, 2019	—	December 31, 2019	$39,261.04

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

5. Recalculation

Benefits for dependent children are 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.

6. Foster Parents

Where a foster parent assumes responsibility for the care and maintenance of a deceased worker's dependent child or children, 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.

7. Commencement of Benefits

Benefits under this Item commence on the day after the date of the worker's death.

PRACTICE

For any relevant PRACTICE information, please consult the WorkSafeBC website at worksafebc.com.

EFFECTIVE DATE: June 30, 2002
AUTHORITY: Sections 17(3)(f) and (g) 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 – Surviving 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*.

HISTORY:

Housekeeping amendments made on March 1, 2012 in accordance with amendments to the *Act*.
Housekeeping amendments made on November 24, 2011 in accordance with amendments to the *Act*.
Replaces 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 17:

(3) Where compensation is payable as the result of the death of a worker or of injury resulting in such death, compensation must be paid to the dependants of the deceased worker as follows:

(j) where the worker leaves no dependent surviving spouse, or the surviving spouse subsequently dies, and the Board considers it desirable to continue the existing household, and when a suitable person acts as a foster parent in keeping up the household and taking care of and maintaining the children entitled to compensation, in a manner satisfactory to the Board, the same allowance is payable to the foster parent and children as would have been payable to a surviving spouse and children, and must continue as long as those conditions continue.

POLICY

Foster Parents

Where the worker leaves dependent children, but no dependent surviving spouse, or the surviving spouse subsequently dies, the Board may consider it desirable to continue the existing household. When a suitable person acts as a foster parent in keeping up the household and taking care of and maintaining the children entitled to compensation, in a manner satisfactory to the Board, the same benefits are payable to the foster parent and children as would have been payable to a surviving spouse and children under Item C8-56.00. The benefits continue 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 17(3)(j) 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 allowance includes the lump sum payable to the surviving spouses referred to in Item C8-55.00.

PRACTICE

For any relevant PRACTICE information, please consult the WorkSafeBC website at worksafebc.com.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Section 17(3)(j) 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 – Surviving Spouse with Children*; Item C8-57.00, *Compensation on the Death of a Worker – Recalculation of Compensation on a Change in Circumstances*.
HISTORY:	Housekeeping amendments made on November 24, 2011 in accordance with amendments to the *Act*. Replaces 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 – Other Dependants and Dependent Parents	ITEM:	C8-56.60

BACKGROUND

1. Explanatory Notes

This policy describes the calculation of compensation for “other dependants” and dependent parents of a deceased worker.

2. The Act

Section 17:

(3) Where compensation is payable as the result of the death of a worker or of injury resulting in such death, compensation must be paid to the dependants of the deceased worker as follows:

(h) where there is

(i) no dependent spouse or child entitled to compensation under this section, but a worker leaves other dependants, a sum reasonable and proportionate to the pecuniary loss suffered by those dependants by reason of the death, to be determined by the Board, but not exceeding in the whole $644.99 per month for life or a lesser period as determined by the Board; or

(ii) a dependent spouse, or a dependent child or children, entitled to compensation under this section, but not a spouse and child or children, and, in addition, the worker leaves a dependent parent or parents, then, in addition to the compensation payable to the spouse or children, a sum, reasonable and proportionate to the pecuniary loss suffered by the dependent parent or parents by the death, to be determined by the Board, but not exceeding $644.99 per month for life or 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 benefits 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. Other Dependants

Where there is neither a dependent spouse nor children entitled to benefits 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 members of the worker's family who were wholly or partly dependent on the worker's earnings at the time of the worker's death:

- parent(s) or stepparent(s);
- person who stood in place of a parent to 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 member of the worker's family 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.

3. Dependent Parents

Where there is either a dependent spouse or a dependent child or children entitled to benefits as a result of a worker's death, but not a spouse and child or children, compensation is payable for the dependent parent or parents of the deceased worker.

The compensation payable to a dependent parent is in addition to the compensation payable to a dependent spouse or to a 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.

4. Calculation of Compensation

Compensation for a dependant under this Item is a sum determined by the Board to be 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 exceed the following amount:

January 1, 2018	—	December 31, 2018	$629.60
January 1, 2019	—	December 31, 2019	$644.99

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

5. Commencement of Benefits

Benefits under this Item commence on the day after the date of the worker's death.

6. Duration of Benefits

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 benefits should be terminated when the grandchild ceases to attend school.

PRACTICE

For any relevant PRACTICE information, please consult the WorkSafeBC website at worksafebc.com.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	Section 17(3)(h) 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*.
HISTORY:	Housekeeping changes made on March 1, 2012 in accordance with amendments to the *Act*. Housekeeping amendments made on November 24, 2011 in accordance with amendments to the *Act*. Replaces 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, though not dependent upon the worker's earnings, had a reasonable expectation of pecuniary benefit from the worker.

2. The Act

Section 17:

(3) Where compensation is payable as the result of the death of a worker or of injury resulting in such death, compensation must be paid to the dependants of the deceased worker as follows:

(i) where

(i) no compensation is payable under the foregoing provisions of this subsection; or

(ii) 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 parent who, though 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, payments, at the discretion of the Board, to that spouse, child or children, parent or parents, but not to more than one of those categories, not exceeding $644.99 per month for life or a lesser period determined by the Board.

POLICY

1. Persons with a Reasonable Expectation of Pecuniary Benefit

This Item applies where

(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 parent or parents who, though not dependent upon the worker's earnings at the time of 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. There must be objective evidence that the worker would have provided an actual monetary benefit to the spouse, child or parent if he or she 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 he or she is a dependant of the deceased worker will automatically be considered under this Item if it is concluded that the person was not wholly or partly dependent upon 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 exceed the following amount:

January 1, 2018	—	December 31, 2018	$629.60
January 1, 2019	—	December 31, 2019	$644.99

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

3. Commencement of Benefits

Benefits under this Item commence on the day after the date of the worker's death.

4. Duration of Benefits

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 benefits for life because the parent's expectation of pecuniary benefit was not a lifelong expectation.

PRACTICE

For any relevant PRACTICE information, please consult the WorkSafeBC website at worksafebc.com.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Section 17(3)(i) 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"*.
HISTORY:	Replaces policy item #60.00 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 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 17:

(4) Where an invalid spouse ceases to be an invalid, or a surviving spouse with dependent children no longer has dependent children or there is a reduction in the number of dependent children, the spouse, surviving spouse or children is then entitled to the same category of benefits as would have been payable if the death of the worker had occurred on the date the invalid spouse ceases to be an invalid or the surviving spouse no longer has dependent children, or the number of dependent children is reduced, as the case may be.

(5) Where there is a surviving spouse and a child or children, and the surviving spouse subsequently dies, the allowances to the children must, if they are in other respects eligible, continue and be calculated in the same manner as if the worker had died leaving no dependent spouse.

Section 35.2

(4) Subject to subsections (5) and (6), in recalculating compensation under section 17(4) or (5), the Board must, if the actual date of the death of a worker was before June 30, 2002, base the recalculation on this Act as it read immediately before June 30, 2002.

(5) Subject to section 19(2.1) of this Act, section 25 of this Act, as amended by the *Skills Development and Labour Statutes Amendment Act, 2003,* applies to compensation paid on or after the transition date in respect of the death of a worker irrespective of the date the worker died.

(6) Commencing on the transition date, for the purposes of applying subsections (3) and (4), the Board must adjust the dollar amounts referred to in sections 17 and 18 and Schedule C of this Act, as it read immediately before June 30, 2002, in accordance with section 25.2(1), as amended by the *Skills Development and Labour Statutes Amendment Act, 2003*.

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) an invalid spouse ceases to be an invalid;

(b) a surviving spouse with dependent children no longer has dependent children;

(c) there is a reduction in the number of dependent children; or

(d) there is a surviving spouse and a child or children, and the surviving spouse subsequently dies.

When a change in circumstances occurs, as described in (a) to (d) 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 (d) above, where a worker is survived by a dependent surviving spouse and children, and the surviving spouse subsequently dies, benefits are recalculated as if the worker died leaving no surviving spouse. In such a situation, benefits for the children would be determined under Item C8-56.40.

When recalculating benefits on a change in circumstances, it is necessary to determine the amount of compensation 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 benefits. For example, where a child who is no longer attending school turns 19 on December 15, the old benefit levels remain in effect until December 14 and the new benefits 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 benefits payable to them. They are also advised in advance of a potential change in their benefits 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 upon the *Act* 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 policy item #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 *Act*, as it read immediately before June 30, 2002, are adjusted in accordance with policy item #51.20 of Volume II of this *Manual*.

PRACTICE

For any relevant PRACTICE information, please consult the WorkSafeBC website at worksafebc.com.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	Sections 17(4) and (5) and sections 35.2(4), (5) and (6) of the *Act*.
CROSS REFERENCES:	Policy item #51.00, *Cost of Living Adjustments to Periodic Payments*; Policy item #51.20, Dollar Amounts in the *Act*; 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 C8-56.00, *Compensation on the Death of a Worker – Calculation of Compensation – Surviving Spouse with Children*; Item C8-56.10, *Compensation on the Death of a Worker – Calculation of Compensation – Surviving Spouse with No Children*; Item C8-56.40, Compensation on the Death of a Worker – Calculation of Compensation – Children.

HISTORY: Housekeeping amendments made on November 24, 2011 in accordance with amendments to the *Act.*
Replaces 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 17:

(14) Where in any situation there is a need to apportion allowances payable to dependants among those dependants, the formula for apportionment must be at the discretion of the Board; but, unless the Board has grounds for a different apportionment, the apportionment must be:

(a) where there is a dependent spouse and one child, 2/3 to the dependent spouse and 1/3 to the child;

(b) where there is a dependent spouse and more than one child, ½ to the dependent spouse and ½ among the children in equal shares; and

(c) where there are children but no dependent spouse, among the children in equal shares.

POLICY

Where in any situation there is a need to apportion allowances 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) where there is a dependent spouse and one child, two-thirds to the dependent spouse and one-third to the child;

(b) where there is a dependent spouse and more than one child, one-half to the dependent spouse and one-half among the children in equal shares; and

(c) where there are children but no dependent spouse, among the children in equal shares.

PRACTICE

For any relevant PRACTICE information, please consult the WorkSafeBC website at worksafebc.com.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Section 17(14) 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"*.
HISTORY:	Replaces 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 17:

(16) If a dependant is entitled to receive compensation

(a) as a result of the death of a worker, 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.

(16.1) The compensation payable for a dependant under subsection (16) must not

(a) be less than the highest of the amounts that would otherwise be payable in respect of the death of any of the workers, and

(b) be more than 90% of the average net earnings of a worker whose wage rate is the maximum wage rate established under section 33(6) and (7) for the year in which the last death referred to in subsection 16(b) occurred.

(16.2) For the purposes of subsection (16.1), “average net earnings” means the average net earnings calculated in accordance with section 33.8.

POLICY

Death of More than One Worker

Where 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 highest of the amounts payable as a result of the death of any of the workers.

The maximum benefits payable are 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 policy item #71.10.

(c) Benefits payable are based upon 90% of the short-term average net earnings.

PRACTICE

For any relevant PRACTICE information, readers should consult the Rehabilitation and Compensation Services Division's Practice Directives available on the WCB website.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	Sections (16), (16.1) and (16.2) of the *Act*.
CROSS REFERENCES:	Short-term Average Net Earnings (policy item #71.10) of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	Replaces 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 the calculation of benefits where a worker is injured or killed in the course of employment as a direct result of enemy warlike action or counteraction.

2. The Act

Section 17:

> (15) Where personal injury to, disablement of or death of a worker occurs in the course of the worker's employment as a direct result of enemy warlike action or counteraction taken against it and provision has been made for compensation in respect of it for the worker or the worker's dependants by the government of Canada, the worker or the dependants are entitled to compensation under this Part only when 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 where:

(a) personal injury to, or disablement or death of, a worker occurs in the course of 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 under the *Act*, benefits are 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 under the *Act*.

PRACTICE

For any relevant PRACTICE information, readers should consult the Rehabilitation and Compensation Services Division's Practice Directives available on the WCB website.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Section 17(15) of the *Act*.
CROSS REFERENCES:	Compensation on the Death of a Worker – Definitions – Meaning of "Dependant" and Presumptions of Dependency (Item C8-53.00) of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	Replaces 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 17:

> (17) Where a situation arises that is not expressly covered by this section, or where some special additional facts are present that would, in the Board's opinion, make the strict application of this section inappropriate, the Board must make rules and give decisions it considers fair, using this section as a guideline.

POLICY

Special or Novel Cases

Where a situation arises that is not expressly covered by the provisions discussed in this chapter or where some special additional facts are present that would, in the Board's opinion, make the strict application of those provisions inappropriate, the Board may make rules and give decisions it considers fair, using those provisions as a guideline.

PRACTICE

For any relevant PRACTICE information, readers should consult the Rehabilitation and Compensation Services Division's Practice Directives available on the WCB website.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Section 17(17) of the *Act*.
CROSS REFERENCES:	
HISTORY:	Replaces policy item #61.40 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 Interest Payment Arising from the Application of Section 19(2) **ITEM: C8-61.10**

BACKGROUND

1. Explanatory Notes

This policy describes the interest payable to a person whose monthly payments are reinstated under section 19(2) of the *Act*.

2. The Act

Section 19:

(1) In this subsection and subsections (2) and (2.1)

"former subsection" means the section 19(1) that came into force on April 17, 1985 or the section 19(4) repealed in 1994;

"interest" means interest calculated at a rate and in a manner set by the Board for the purposes of this section;

"monthly payments" mean monthly payments under this Act to a widow, widower, former common law wife or former common law husband of a deceased worker;

"person" does not include a widow or former common law wife of a deceased worker if the widow or former common law wife remarried or entered into a new common law relationship before April 17, 1985.

(2) A person whose monthly payments were discontinued by application of a former subsection is entitled to

(a) monthly payments beginning on the later of

(i) the expiry of the 2 year period for which payment was made under the former subsection, or

(ii) the repeal of the former subsection,

(b) the amount, if any by which, during the period from April 17, 1985 to the beginning of monthly payments under paragraph (a), the total amount of compensation described by section 17 that the person would have received if the former subsection had not been in force exceeds the sum paid to the person under the former subsection, and

(c) interest on any amount payable under paragraph (b).

(2.1) In calculating monthly payments for the purposes of subsection (2), adjustments are deemed to have been made under section 25, as it read immediately before being amended by the *Workers Compensation Amendment Act, 2002*, for the months the former subsection was in force.

POLICY

Interest Payment Arising from the Application of Section 19(2)

Where interest is payable as a result of the application of section 19(2), it is calculated at the rates and in the manner set out in policy item #50.00.

PRACTICE

For any relevant PRACTICE information, readers should consult the Rehabilitation and Compensation Services Division's Practice Directives available on the WCB website.

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Section 19 of the *Act*.
CROSS REFERENCES:	Interest (policy item #50.00) of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	Replaces policy item #55.61 of the *Rehabilitation Services & Claims Manual,* Volume II.
APPLICATION:	This Item applies to interest payable under section 19(2) of the *Act* 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 20:

> The Board may from time to time require the proof of the existence and condition of dependants in receipt of compensation payments that is deemed necessary by the Board, and pending the receipt of that proof may withhold further payments.

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 section 17 of the *Act*, declaration forms and school attendance forms. Failure to complete and return these forms may result in payments being withheld pending their receipt by the Board.

PRACTICE

For any relevant PRACTICE information, readers should consult the Rehabilitation and Compensation Services Division's Practice Directives available on the WCB website.

EFFECTIVE DATE: December 31, 2003
AUTHORITY: Section 20 of the *Act*.
CROSS REFERENCES: Compensation on the Death of a Worker – Definitions – Meaning of "Dependant" and Presumptions of Dependency (Item C8-53.00) of the *Rehabilitation Services & Claims Manual,* Volume II.

HISTORY: Replaces 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 4:

(3) Where the death of a commercial fisher resident in British Columbia arises out of and in the course of his or her occupation in the Province or waters off the Province after January 1, 1975, and the death is not otherwise compensable under this Part, the Board may treat the death in the same manner as if the commercial fisher were a worker employed by the Crown in the right of the Province.

POLICY

Death of a Commercial Fisher

Where the death of a commercial fisher resident in British Columbia arises out of and in the course of his or her occupation in the Province or waters off the Province after January 1, 1975, and the death 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 the Province.

PRACTICE

EFFECTIVE DATE:	December 31, 2003
AUTHORITY:	Section 4(3) of the *Act*.
CROSS REFERENCES:	
HISTORY:	Replaces 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.

CHAPTER 9

AVERAGE EARNINGS

#64.00 INTRODUCTION

Section 33(1) of the *Act* provides, in part:

> The Board must determine the amount of average earnings and the earning capacity of a worker with reference to the worker's average earnings and earning capacity at the time of the worker's injury.

This section 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 is calculated differently. The exceptions relate to a casual worker, a person who purchased coverage under section 2(2) of the *Act*, a worker with no earnings on the date of injury, 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. Where more than one exception applies to a worker, 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 below 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.

#65.00 GENERAL RULE FOR DETERMINING SHORT-TERM AVERAGE EARNINGS

Section 33.1(1) of the *Act* provides as follows:

> Subject to sections 33.5 to 33.7, the Board must determine, for the shorter of the following periods, the amount of average earnings of a worker

based on the rate at which the worker was remunerated by each of the employers for whom he or she was employed at the time of injury:

(a) the initial payment period;

(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.

Except for a casual worker, a person who purchased coverage under section 2(2) of the *Act* and a worker with no earnings at the time of injury, 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 standard five-day work week, the determination of time of injury earnings will be based on the worker's rate of pay on the day of injury.

The Board recognizes that not all workers receive remuneration based on a five-day work week. Policy items #65.01, #65.02, and #65.03 detail how the Board will determine the earnings at the time of injury for workers in other circumstances.

EFFECTIVE DATE: June 1, 2009
CROSS REFERENCE: Policy items #65.01 *Variable Shift Workers,* #65.02 *Worker with Two Jobs,* #65.03 *Fishers,* #67.10 *Casual Pattern of Employment,* #67.20 *Personal Optional Protection* and policy item #67.30 *Workers with No Earnings* of the *Rehabilitation Services & Claims Manual* Volume II.
APPLICATION: To all decisions on or after June 1, 2009.

#65.01 Variable Earnings

The Board recognizes that not all workers receive remuneration based on a regular five-day work week. Accordingly, calculating time of injury earnings based on a worker's rate of pay on the day of 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. However, the Board may use a shorter time period if it determines that the three month time period is not an accurate reflection of the worker's time of injury earnings.

Situations where a shorter time period may be used include:

- where 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 injury.
- where the worker received wage-loss compensation (or wage-loss equivalent rehabilitation allowances/benefits) during the three month period prior to the date of injury.
- where 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 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 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.

EFFECTIVE DATE:	June 1, 2009
CROSS REFERENCE:	Policy item #65.00 *General Rule for Determining Short-Term Average Earnings* and policy item #67.10 *Casual Pattern of Employment* of the *Rehabilitation Services & Claims Manual* Volume II.
APPLICATION:	To all decisions on or after June 1, 2009.

#65.02 Worker with Two Jobs

If a worker holds two jobs and is disabled from both by an injury arising out of and in the course of one of them, time of injury earnings will be based on the combined earnings of both jobs up to the statutory maximum. This applies whether or not the other job is covered by Part 1 of the *Act* or is self-employment. The total days worked in both jobs are merged to obtain the days worked per week. Both employers, if covered by Part 1 of the *Act*, may be reimbursed by the Board if they continue paying the disabled worker. (1)

Where a worker is engaged in two jobs, one of which is a job for which personal optional protection has been purchased, the income earned in the non-personal optional protection job will be combined with the amount of personal optional protection purchased for the other job, up to the statutory maximum, in order to determine average earnings.

EFFECTIVE DATE: June 1, 2009
CROSS REFERENCE: Policy items #34.40 *Pay Employer Claims,* #65.00 *General Rule for Determining Short-Term Average Earnings,* #67.10 *Casual Pattern of Employment* and policy item #67.20 *Personal Optional Protection* of the *Rehabilitation Services & Claims Manual* Volume II.
APPLICATION: To all decisions on or after June 1, 2009.

#65.03 Fishers

The time of injury earnings 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 injury. Where 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 policy item #68.62 for information on a fisher's composition of average earnings where 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.

EFFECTIVE DATE: June 1, 2009
CROSS REFERENCE: Policy item #65.00 *General Rule for Determining Short-Term Average Earnings* and policy item #68.62 *Fishers* of the *Rehabilitation Services & Claims Manual* Volume II.
APPLICATION: To all decisions on or after June 1, 2009.

#65.04 Provisional Rate

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.

Where 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.

Section 96(5) of the *Act* provides that the Board may not reconsider a decision on the worker's average earnings if more than 75 days have passed since the decision was made. The Board may also not reconsider a decision on the worker's average earnings if a request for review has been made to the Review Division as provided for by section 96.2 of the *Act*.

A preliminary determination to set a provisional rate is not a "decision" for the purposes of section 96(5). 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 96(5).

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, regard will be had to the applicable statutory minimum. See policy item #93.26 regarding a worker's obligation to provide information. (2) 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 policy item #48.41.

EFFECTIVE DATE: May 1, 2010
HISTORY: May 1, 2010 – Amendments to clarify when a provisional rate may be used and to change references to average net earnings to average earnings.
June 1, 2009 – Delete references to Board officers.
March 3, 2003 – Amendments 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 on or after May 1, 2010

#65.05 Workers Participating in Non-Board Sponsored Return to Work Programs

Where 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 his or her 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 policy item #67.60 to determine the long-term average earnings for a worker participating in a non-Board sponsored Return to Work program.

EFFECTIVE DATE: March 1, 2009
APPLICATION: Applies to all decisions made on or after the effective date.

#66.00 GENERAL RULE FOR DETERMINING LONG-TERM AVERAGE EARNINGS

Section 33.1(2) of the *Act* provides:

> Subject to sections 33.2 to 33.7, if a worker's disability continues after the end of the period referred to in subsection (1) (a) and (b) that is shorter for the worker, the Board must, for the period starting after the end of that shorter period, determine the amount of average earnings of the worker based on the worker's gross earnings, as determined by the Board, for the 12 month period immediately preceding the date of the injury.

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 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, T-4's, or letters from the Income Tax Authorities or employers.

If, at the earlier of: the day after 10 cumulative weeks of benefits have been paid to the worker; or the effective date of a permanent disability award there is insufficient information on which to complete the 10-week rate review, a provisional rate may be set until sufficient information is received. (3)

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: January 1, 2016
HISTORY: By Board of Directors resolution 2015/11/25-02, the application statement of this policy was revised on November 25, 2015.

APPLICATION: Applies to all decisions, including appellate decisions, made on or after January 1, 2016.

#67.00 EXCEPTIONS TO THE GENERAL RULES FOR DETERMINING AVERAGE EARNINGS

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 33.1(3), the *Act* provides that if two or more exceptions to the general rules for determining average earnings apply to a worker, 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 33.2) who had been employed less than 12 months (section 33.3). 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.

#67.10 Casual Pattern of Employment

Section 33.5 of the *Act* provides:

> 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 average earnings under section 33.1 from the date of the 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.

This 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 the 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 section 33.1 general rule should apply;

   (b) those workers who are an apprentice or learner, to whom the section 33.2 exception applies;

   (c) those workers who are employed, on other than a casual or temporary basis, by the employer for less than 12 months immediately preceding the date of the injury, to whom the section 33.3 exception applies; and

   (d) those workers who have purchased coverage under section 2(2) of the *Act*, to whom the section 33.6 exception applies.

   Certain workers will not clearly fall within the above categories. An indicator that a worker may fall within the section 33.5 exception is that their 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. Where 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. Normally, one year would be the maximum period of inquiry.

   The following are factors or characteristics that may favour categorization of a worker's pattern of employment as casual in nature:

   - The worker has uncertain or unpredictable working hours.

   - The worker has a significant variation in weekly earnings.

   - The worker has the option to accept or reject requests to work without penalty.

   - The worker works "on call" for one or more employers. In certain cases, however, a worker who works on call for one or more employers may have predictable, consistent working hours which may reflect a regular pattern of employment for which the section 33.1 general rule might apply.

An employer's reference to a worker as a "casual worker" is not conclusive of the worker's categorization. All relevant factors must be considered and no single factor is determinative. Relevant factors not listed in policy may also be considered.

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.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officer and decision-maker.
HISTORY:	January 1, 2006 – Amendments 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.
APPLICATION:	Applies on or after June 1, 2009

#67.20 Personal Optional Protection

Section 33.6 of the *Act* provides:

> If an independent operator or employer, to whom the Board directs that this Part applies under section 2(2), has purchased coverage under this *Act*, the Board must determine the amount of average earnings under section 33.1 from the date of injury based on the gross earnings for which coverage is purchased.

This is an exception to both general rules for determining average earnings. The average earnings of a person entitled to personal optional protection under section 2(2) of the *Act* (4) are the earnings for which coverage has been purchased. There is no 10-week average earnings review.

The maximum and minimum amount of earnings for which coverage can be purchased may be obtained by contacting the Board.

Where an applicant is applying for personal optional protection in an amount which exceeds the maximum per month, proof of gross earnings must be provided. If verification of earnings is not provided, the Board automatically reduces coverage to the maximum per month. Proof of gross earnings must be in the form of a certified copy of the applicant's previous year's tax return or a declaration must be completed by a professional accountant (C.A., C.G.A., or C.M.A.), lawyer or notary public. This declaration must certify that the self-employed earnings of the applicant for the previous year were equal to or exceeded the coverage requested.

Because of frequent changes in the maximum wage rate, where coverage at the maximum has been granted, the Board permits an application for personal optional protection at the “maximum wage rate” with coverage and assessment to be adjusted automatically from time to time.

Where 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 22(2), 23(4), 29(2) and 30(2) have no application to persons who have purchased personal optional protection. (5) However, the minimum average earnings provided for in section 17(3)(g) does apply. (6)

The amount of personal optional protection 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 policy item #71.00.

Compensation payable to persons entitled to personal optional protection is subject to the same cost of living adjustments as compensation payable to other persons.

EFFECTIVE DATE: March 18, 2003 (as to where the maximum and minimum wage rate figures may be obtained)

APPLICATION: Not applicable.

#67.30 Workers with No Earnings

Section 33.7 of the *Act* provides:

> If a worker had no earnings at the time of injury, the Board must determine the amount of average earnings of a worker under section 33.1 from the date of injury in a manner that the Board considers appropriate.

This is an exception to both general rules for determining average earnings. There is no 10-week average earnings review.

Persons working without pay are not generally considered as “workers” under the *Act*. However, there are some exceptional situations of this type which are covered and for which the *Act* or the Board has specified the earnings on which compensation is to be based. These situations are described in policy items #67.31 – #67.34.

#67.31 Volunteer Workers Admitted by the Board under Section 3(5)

Where a person who is deemed to be a worker under section 3(5) of the *Act* is not regularly employed, and having regard to all the circumstances, including income, the Board may fix the worker's average earnings at not less than the amount set out below per week nor more than the maximum wage rate provided under section 33 of the *Act*.

January 1, 2018	—	December 31, 2018	$135.30
January 1, 2019	—	December 31, 2019	$138.61

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

The minimum wage set out above is subject to cost of living adjustments as described in policy item #51.20.

#67.32 Volunteer Firefighters and Ambulance Drivers and Attendants

The average earnings of volunteer ambulance drivers and attendants and members of fire brigades 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. (7)

In order to provide a minimum level of coverage to volunteers 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 municipality 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 is unemployed, but has an attachment to the labour force in the sense that the volunteer is seeking employment, wage-loss benefits are determined on the average earnings from the last regular employment. The fact that the volunteer is collecting Employment Insurance benefits confirms for compensation purposes an attachment to the labour force. The 12 months immediately preceding the volunteer's date of injury will be used to determine the level of benefits. See policy item #68.40 with respect to employment insurance income and the composition of average earnings. If a 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 municipality 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 AP1-1-5 and AP1-38-3 of the *Assessment Manual* or firefighters whose employers are not covered by Part 1 of the *Act*, but to whom personal optional protection has been given, are to be assessed and paid on the same basis as above.

EFFECTIVE DATE:	June 1, 2009 – Delete reference to Board officer.
HISTORY:	March 18, 2003 – Insert references to Items AP1-1-5 and AP1-38-3 in the *Assessment Manual.*
APPLICATION:	Applies on or after June 1, 2009

#67.33 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.

#67.34 Emergency Services Workers

Average earnings used in claims by Emergency Services Workers 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*. (8)

#67.40 Apprentice or Learner

Section 33.2 of the *Act* provides:

(1) This section applies to a worker who, at the time of injury, is an apprentice in a trade, an occupation or a profession, or is a person referred to in paragraph (b) of the definition of "worker".

(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 average earnings of the worker based on the greater of:

(a) the rate at which the worker was remunerated by each of the employers for whom he or she 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 average earnings of the worker 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.

This is an exception to the general rule for determining long-term average earnings.

The Board considers that an "apprentice in a trade" is an apprentice as defined under the terms and conditions in the provincial *Industry Training and Apprenticeship Act* or equivalent statute. The *Industry Training and Apprenticeship Regulation* or equivalent provides a list of trades that require compulsory certification.

The Board 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.

Section 33.2 of the *Act* includes a worker referred to in paragraph (b) of the section 1 definition of "worker". Paragraph (b) of the definition of "worker" provides that a worker includes:

> a person who is a learner, although not under a contract of service or apprenticeship, who becomes subject to the hazards of an industry within the scope of Part 1 for the purpose of undergoing training or probationary work specified or stipulated by the employer as a preliminary to employment.

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 Part 1 of the *Act*. A person is not a learner when the person is under a contract or an apprenticeship.

Where a worker's injury results in a temporary disability which continues after the initial 10 week period, the Board determines the worker's average earnings based on the greater of:

(a) the rate at which the worker was remunerated by each of the employers for whom he or she 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.

Where a worker's injury results in a permanent disability, the Board calculates the average earnings in accordance with section 33.2(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.

Where 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 relevant information 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 33.2(3) of the *Act* applies 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 a permanent disability award. It will also be used to calculate wage-loss equivalency benefits while a worker participates in a vocational rehabilitation plan.

Effective Date:	July 1, 2012
Cross References:	Policy item #65.00, *General Rules for Determining Short-Term Average Earnings*; Policy item #66.00, *General Rules for Determining Long-Term Average Earnings*.
Application:	Applies to an injury that occurs on or after July 1, 2012

#67.50 Workers Employed with their Employer for Less than 12 Months

Section 33.3 of the *Act* provides:

> In the case of a worker employed, on other than a casual or temporary basis, by the employer for less than 12 months immediately preceding the date of the injury, the Board's determination of the amount of average earnings under section 33.1(2) 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.

This is a mandatory exception to the general rule for determining long-term average earnings and applies a worker with permanent employment.

To determine a worker's average earnings under section 33.3 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.

Where 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 relevant information 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.

#67.60 Exceptional Circumstances

Section 33.4 of the *Act* provides:

> (1) If exceptional circumstances exist such that the Board considers that the application of section 33.1(2) would be inequitable, the Board's determination of the amount of average earnings of a

worker 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 sections 33.2, 33.3, 33.5 or 33.6.

As stated in section 33.4(2), this provision does not apply to the following:

- a worker determined by the Board to be an apprentice or a learner;
- a permanently employed worker who has been employed by the employer for less than 12 months;
- a casual worker; or
- a person who purchased coverage under section 2(2) of the Act.

Section 33.4 is a discretionary provision and an exception to the application of section 33.1(2) for determining a worker's long-term average earnings. As such, it will only be applied where the Board determines that, due to exceptional circumstances, the application of section 33.1(2) is inequitable.

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. 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) An exceptional circumstance affecting a worker's average earnings is any prior period(s) when a worker received wage-loss compensation (or wage-loss equivalent rehabilitation allowances/benefits) during the 12 month period immediately preceding the worker's date of injury. It would be inequitable to reduce a worker's average earnings by including periods of

compensable wage-loss (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 benefits, temporary partial disability benefits, a vocational rehabilitation training allowance or other types of wage replacement benefits.

The Board excludes any periods during which the worker received wage-loss compensation (or 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) Where the Board determines that the worker has a regular pattern of employment, and 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) Where 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, where 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 his or her 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 student is unable to continue in his or her 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 where 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) Where 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 where 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: May 1, 2008
APPLICATION: Applies to all decisions including appellate decisions made on or after May 1, 2008.

#68.00 COMPOSITION OF AVERAGE EARNINGS

A worker's average earnings is normally composed of wages or salary. However, the Board recognizes that a worker may receive other types of payments. Board policy on the treatment of specific types of payments is set out in policy items #68.10 to #68.80.

#68.10 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 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 setting the wage rate on a claim.

#68.11 Overtime

Only regular overtime is included in the calculation of a worker's average earnings.

#68.12 Severance or Termination Pay

Severance or termination pay received by a worker is not included in the calculation of average earnings.

#68.13 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.

#68.20 Employment Benefits

#68.21 Benefit Plans

Section 33(3.1) of the *Act* provides:

> The Board must not include the following in determining the amount of average earnings of a worker:
>
> (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 another benefit plan for the worker or the worker's dependants….

The Board does not include these employment benefits as a component of average earnings.

#68.22 Room and Board

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.

A distinction should be made between room and board which is provided in total or in part by an employer as the remuneration for services rendered and room and board incurred as a business expense by the employer.

One example of a business expense is where an official of a company makes a business visit out of town and incurs the cost of hotel and meals. On return, the official 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.

A situation where room and board 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. Where specific evidence is not available, 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 compensation representing the dollar value of the room and board would be paid directly to the worker.

EFFECTIVE DATE:	December 1, 2010
CROSS REFERENCES:	Policy item #34.40 Pay Employer Claims and policy item #68.00 Composition of Average Earnings of the *Rehabilitation Services & Claims Manual*, Volume II
APPLICATION:	Applies to all decisions made on or after December 1, 2010.

#68.23 Special Expenses or Allowances

Section 33(3.1) of the *Act* provides, in part:

> The Board must not include the following in determining the amount of average earnings of a worker:
>
> (a) …
>
> (b) special expenses or allowances paid to the worker because of the nature of the worker's employment.

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.

#68.30 Strike Pay

Strike pay is not included when calculating a worker's earnings.

#68.40 Employment Insurance Payments

Section 33(3.2) of the *Act* provides:

> The Board may include, in determining the amount of average earnings of a worker, income from employment benefits payable to the worker under the *Employment Insurance Act* (Canada) during the period for which average earnings are determined only if, in the Board's opinion, the worker's employment during that period was in an occupation or industry that results in recurring seasonal or recurring temporary interruptions of employment.

This is a discretionary provision and will be applied only where there is verified evidence from an independent source that the worker received employment insurance benefits due to the worker's employment in an occupation or industry that results in recurring seasonal or temporary interruptions of employment.

The Board may collect the necessary data to compile a list of industries and occupations that result in recurring seasonal or temporary interruptions of employment. The list must give regard to regional considerations and may adopt information from sources such as British Columbia Statistics, Statistics Canada or Human Resources and Skills Development Canada.

EFFECTIVE DATE:	June 1, 2009 – Update reference to Human Resources and Skills Development Canada.
APPLICATION:	Applies on or after June 1, 2009

#68.50 Property Value Losses

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

#68.60 Payments in Respect of Equipment

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

#68.61 Workers Deducting Business and/or Equipment Expenses

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

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

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

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

(a) Short-Term Average Earnings

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

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

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

(i) Light Equipment

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

Equipment	Wages
15%	85%

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

(ii) Medium Equipment

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

Equipment	Wages
40%	60%

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

(iii) Heavy Equipment

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

Equipment	Wages
75%	25%

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

(b) Long-Term Average Earnings

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

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

1) Did the worker's gross earnings for the time period under review include payment in respect of the expense?

2) Did the worker incur the expense directly as a result of supplying equipment and/or materials to the employer?

3) Did the expense result from the worker operating his or her business?

4) Would the worker incur the expense regardless of the nature of the employment?

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

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

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

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

Interest accrued (whether paid or not) as the result of debt in respect of equipment owned by a worker that is a required component of the contract of service is considered a business expense. The accrued interest is deducted from gross income.

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

#68.62 Fishers

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

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

1) Did the fisher's gross earnings for the time period under review include payment in respect of the expense?

2) Did the fisher incur the expense directly as a result of supplying equipment and/or materials for fishing activities?

3) Did the expense result from the fisher operating his or her business?

4) Would the fisher incur the expense regardless of the nature of the employment?

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

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

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

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

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

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

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

#68.70 Payments to Substitutes

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

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

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

#68.80 Government Sponsored Work Programs

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

1. The simple continuation of Employment Insurance, Welfare or other benefits.

2. A "top-up" of Employment Insurance, Welfare or other benefits. Full payment by the employer, subsidized either in whole or in part from Employment Insurance, Welfare or other government funds. In cases of this type, the composition of average earnings is made up of the total dollar amount being paid to the worker either by the employer or the sponsoring government agency or a combination of either.

#68.90 Principals – Composition of Earnings

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 is entitled to rely upon this assertion unless there is good evidence to the contrary. Even if, upon investigation, the evidence shows that the spouse or child did not work for the company, that in itself does not mean that the payments to the spouse or child were earnings of the principal. There could be any number of other reasons why the company might make payments to the spouse or child.

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

EFFECTIVE DATE: January 1, 2008
APPLICATION: This policy applies to the calculation of average earnings for principals with injuries that occur on or after January 1, 2008.

#69.00 MAXIMUM AMOUNT OF AVERAGE EARNINGS

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

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

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

	Yearly Applicable
January 1, 2018 – December 31, 2018	$82,700.00
January 1, 2019 – December 31, 2019	$84,800.00

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

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

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

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

#69.10 Deduction of Permanent Disability Periodic Payments from Wage Loss

Section 31(1) provides as follows:

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

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

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

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

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

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

Section 31(2) provides:

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

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

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

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

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

#70.00 AVERAGE EARNINGS ON REOPENED CLAIMS

#70.10 Disability Occurring Within Three Years of Injury

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

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

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

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

1. The annual permanent disability payment amount is calculated by multiplying the monthly figure by 12.

2. The annual permanent disability payment amount is divided by the working days per year to obtain a daily rate.

5-day week	=	261 days
5-1/2-day week	=	287 days
6-day week	=	313 days
7-day week	=	365 days

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

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

EFFECTIVE DATE: October 16, 2002
APPLICATION: To all adjudication decisions made on or after the effective date.

#70.20 Reopenings Over Three Years

Section 32 of the *Act* provides:

(1) For the purpose of determining the amount of compensation payable where there is a recurrence of temporary total disability or temporary partial disability after a lapse of 3 years following the occurrence of the injury, the Board may calculate the compensation as if the recurrence were the happening of the injury if it considers that by doing so the compensation payable would more nearly represent the percentage of actual loss of earnings suffered by the worker by reason of the recurrence of the injury.

(2) Where a worker has been awarded compensation for permanent partial disability for the original injury and compensation for recurrence of temporary total disability under subsection (1) is calculated by reference to the average earnings of the worker at the date of the recurrence, the compensation must be without deduction of the compensation payable for the permanent partial disability; but the total compensation payable must not exceed the maximum payable under this Part at the date of the recurrence.

(3) Where more than three years after an injury a permanent disability or an increased degree of permanent disability occurs, the compensation payable for the permanent disability or increased degree of permanent disability may be calculated by reference to the average earnings of the worker at the date of the occurrence of the permanent disability or increased degree of permanent disability.

This policy sets out how the Board determines compensation benefits if a 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.

When a temporary disability recurs more than three years after the original injury, section 32(1) of the *Act* gives the Board the discretion to calculate a worker's compensation as if the recurrence were the happening 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.

When a permanent disability occurs or increases in degree more than three years after the original injury, section 32(3) 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 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 compares:

- the worker's earnings at the time of the original injury, with applicable cost of living adjustments; and
- the worker's current earnings at the time 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 earnings, which are determined in accordance with sections 33.1 to 33.7 of the *Act*. If no long-term average earnings were previously set, 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 it from 75% of gross average earnings to 90% of average net earnings. This conversion involves using the worker's earnings at the time of the original injury plus applicable cost of living adjustments, and the relevant tax provisions at the time of the recurrence of the temporary disability or at the time the permanent disability occurs or increases in degree.

Cost of living adjustments that occur pursuant to section 25(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 Used to Determine Compensation Payable

Where a worker's current earnings are higher than the original earnings, the current earnings will generally be used to calculate compensation payable. In these cases the Board considers that the current earnings more nearly represent the actual loss of earnings suffered by the worker by reason of the recurrence of temporary disability or occurrence or increase in permanent disability.

Current earnings may be used where a worker has reduced or no earnings at the time of the recurrence of the temporary disability, or at the time the permanent disability occurs or increases in degree, for reasons unrelated to the disability. Examples include, but are not limited to, the following:

- If the worker has no current earnings for reasons unrelated to any disability 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 23(1) of the *Act*. If eligibility is established, the award under section 23(1) of the *Act* is calculated on the basis of the worker's earnings at the time 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 time of the recurrence, or the occurrence or increase of degree of permanent disability.

In these types of situations, the Board considers that the current earnings more nearly represent the actual loss of earnings suffered by the worker by reason of the recurrence of temporary disability or occurrence or increase in permanent disability.

Finally, in the event that the original earnings, plus applicable cost of living adjustments, and the current earnings are equal, compensation benefits are based on the worker's current earnings.

If the current earnings are used to calculate compensation benefits for a recurring temporary disability, the initial payment period provided in section 33.1(1) of the *Act* recommences.

1.2 Original Earnings Used to Determine Compensation Payable

A worker may have reduced or no earnings at the time of the recurrence of temporary disability, or occurrence or increase in degree of permanent disability, because the disability produces a potential for loss of earnings. In these cases, the Board may use the worker's earnings at the time 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 due to the disability, 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 he or she 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 he or she 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 benefits 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.

2. WORKER RECEIVING PERMANENT PARTIAL DISABILITY AWARD FOR THE SAME DISABILITY

When wage-loss compensation for a recurrence of a temporary disability is based on the worker's current earnings and, when there is an existing permanent partial disability award granted in respect of the original injury, section 32(2) applies. Therefore, the permanent disability periodic payment is not deducted from the wage-loss benefits except to the extent that the combined total exceeds the maximum wage rate in effect at the time of the recurrence.

3. PERSONS WITH PERSONAL OPTIONAL PROTECTION

This policy applies to persons who purchased Personal Optional Protection at the time of the original injury and/or at the time 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 Optional Protection coverage purchased in determining the person's earnings.

4. PRIOR OCCASION WHEN SECTION 32 WAS APPLIED

If, on a previous reopening of the claim, section 32 of the *Act* or its predecessor was used to base compensation on the worker's current earnings, any rate resulting from the previous application of section 32 is ignored at the time of the later reopening.

EFFECTIVE DATE: June 1, 2010
APPLICATION: Applies to all decisions made on or after June 1, 2010.

#70.30 Permanent Disability Awards

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

#71.00 AVERAGE NET EARNINGS

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

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

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

(a) probable EI premiums;

(b) probable CPP contributions; and

(c) probable income taxes.

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

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

#71.10 Short-term Average Net Earnings

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

(a) the date temporary disability benefits have been payable to the worker for a cumulative period of 10 weeks; or

(b) the effective date of a permanent disability award.

Schedule of Deductions

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

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

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

Probable CPP and EI

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

Probable Income Taxes

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

(a) credits based on the basic personal amounts, multiplied by 1.5; and

(b) credits for the probable CPP contributions and EI premiums payable for the worker's average earnings.

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

#71.20 Long-term Average Net Earnings

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

(a) the first day after the date temporary disability benefits have been payable to the worker for a cumulative period of 10 weeks; or

(b) the effective date of a worker's permanent disability award.

Formulas for Deductions

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

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

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

Probable CPP and EI

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

Probable Income Taxes

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

(a) credits based on the basic personal amounts;

(b) credits for EI premiums and CPP contributions; and

(c) spousal credit or wholly dependent person credit and/or infirm dependant credit.

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

Exceptions

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

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

EFFECTIVE DATE:	June 1, 2009 – Update reference to Canada Revenue Agency.
APPLICATION:	Applies on or after June 1, 2009

#71.30 Insufficient Information

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

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

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

#71.40 Adjustments

The Board may adjust a worker's average earnings subject to reconsideration rules set out in section 96(5) of the *Act*, where they were based upon incorrect information. If the adjustment results in a decrease in the value of the worker's earnings, the Board will consider policy item #48.41 in determining whether to declare an overpayment. If it results in an increase, a retroactive adjustment may be made.

EFFECTIVE DATE:	June 1, 2009 – Delete reference to Board officer.
HISTORY:	October 1, 2007 – Amendments to include reference to section 96(5) of the *Act* and to delete the term net.
APPLICATION:	Applies on or after June 1, 2009

NOTES

(1) See policy item #34.40

(2) See policy item #34.20

(3) See policy item #65.04

(4) See policy items #34.20; #35.23; #37.20; #39.60

(5) See Item AP1-2-3 of the *Assessment Manual*

(6) See Item C8-56.00 and Item C8-56.40

(7) See Item AP1-1-5 of the *Assessment Manual*

(8) See Item AP1-3-1 of the *Assessment Manual*

~~(9) See policy item #34.40~~ DELETED

(10) s.33(10)

(11) s.33(9)

(12) See policy item #70.20

(13) See policy item #69.00

(14) See policy item #69.10

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:

> "compensation" includes health care;
>
> "health care", when used in Part 1, includes the things which the Board under this *Act* is empowered to provide for injured workers;
>
> "physician" means a person authorized under an enactment to practise in British Columbia as a medical practitioner;
>
> "qualified practitioner" means a person authorized under an enactment to practise in British Columbia as a chiropractor, a dentist, a naturopathic physician, a nurse practitioner or a podiatrist;
>
> "specialist" means a physician residing and practising in the Province and listed by the Royal College of Physicians and Surgeons of Canada as having specialist qualifications;

Section 5(2):

> Where an injury disables a worker from earning full wages at the work at which the worker was employed, compensation is payable under this Part from the first working day following the day of the injury; but a health care benefit only is payable under this Part in respect of the day of the injury.

Section 6(1):

> Where
>
> (a) a worker suffers from an occupational disease and is thereby disabled from earning full wages at the work at which the worker was

employed or the death of a worker is caused by an occupational disease; and

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

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

Section 21(1):

In addition to the other compensation provided by this Part, the Board may furnish or provide for the injured worker any medical, surgical, hospital, nursing and other care or treatment, transportation, medicines, crutches and apparatus, including artificial members, that it may consider reasonably necessary at the time of the injury, and thereafter during the disability to cure and relieve from the effects of the injury or alleviate those effects, and the Board may adopt rules and regulations with respect to furnishing health care to injured workers entitled to it and for the payment of it. The Board may make a daily allowance to an injured worker for the worker's subsistence when, under its direction, the worker is undergoing treatment at a place other than the place where he or she resides, and the power of the Board to make a daily allowance for subsistence under this section extends to an injured worker who receives compensation, regardless of the date the worker first became entitled to compensation.

Section 23.5:

(1) If a worker has a permanent total disability, the Board must assess, within the 3 month period before the retirement benefit is payable to the worker, the need or continued need of the worker for services and personal supports under sections 16 and 21.

(2) After the assessment under subsection (1) is completed, the Board must take all actions necessary to provide to the worker, for his or her life, the services and personal supports under sections 16 and 21 that the Board considers are 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 sections 16 and 21.

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, physiotherapists, prosthetists and orthotists, pharmacists, 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, relieve 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 he or she is employed, or is retired from the workforce.

2.3 When a Worker Leaves British Columbia

Workers who reside in British Columbia on the date of injury and subsequently wish to leave the province, 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, *Reduction or Suspension of Compensation*, are met.

The Board does not generally pay in excess of British Columbia rates for health care rendered outside the province to a worker who has voluntarily left the province.

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:	January 1, 2015
AUTHORITY:	Sections 1, 5, 6, 21 and 23.5 of the *Act*.
CROSS REFERENCES:	Policy item #32.50, *"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*; and Chapter 18 – Retirement Benefits.
HISTORY:	January 1, 2015 – Policy amended to include nurse practitioners as qualified practitioners in accordance with changes to the *Act* resulting from Bill 17. This policy consolidates and replaces 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:	This Item applies on or after January 1, 2015.

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 21:

(1) See Item C10-72.00.

(2) Where in a case of emergency, or for other justifiable cause, a physician or qualified practitioner other than the one provided by the Board is called in to treat the injured worker, and if the Board finds there was a justifiable cause and that the charge for the services is reasonable, the cost of the services must be paid by the Board.

…

(6) Health care furnished or provided … must at all times be subject to the direction, supervision and control of the Board; and the Board may contract with physicians, nurses or other persons authorized to treat human ailments, hospitals and other institutions for any health care required, and to agree on a scale of fees or remuneration for that health care; and all questions as to the necessity, character and sufficiency of health care to be furnished must be determined by the Board. …

(7) Without limiting the power of the Board under this section to supervise and provide for the furnishing of health care in every case where it considers the exercise of that power is expedient, the Board must permit health care to be administered, so far as the selection of a physician or qualified practitioner is concerned, by the physician or qualified practitioner who may be selected or employed by the injured worker.

Section 57(1):

> The Board may require a worker who applies for or is in receipt of compensation . . . to be medically examined at a place reasonably convenient for the worker. If the worker fails to attend for the examination or obstructs the medical examiner, the worker's right to compensation is suspended until the examination has taken place, and no compensation is payable during the period of suspension.

POLICY

1. GENERAL

Health care furnished or 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 furnished or provided to 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.

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 his or her own physician or qualified practitioner. For the purpose of section 21 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 his or her 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 him or her, 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, *Reduction or Suspension of Compensation*, 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 policy item #95.30, *Failure to Report*, 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 insanitary or injurious practice, and may reduce or suspend the worker's compensation, if the circumstances in Item C10-74.00, *Reduction or Suspension of Compensation*, 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, 2015
AUTHORITY:	Sections 1, 21 and 57 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*;
Policy item #95.30, *Failure to Report*;
Policy item #97.30, *Medical Evidence*; *and*
Policy item #97.34, *Conflict of Medical Opinion*.

HISTORY: This policy consolidates and replaces 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: This Item applies on or after January 1, 2015.

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 or obstructing a medical examination, and reduce or suspend a worker's compensation for refusing to submit to medical or surgical treatment or persisting in insanitary or injurious practices.

2. The Act

Section 1:

> "compensation" includes health care;
>
> "health care", when used in Part 1, includes the things which the Board under this Act is empowered to provide for injured workers;

Section 57:

(1) The Board may require a worker who applies for or is in receipt of compensation under this Part to be medically examined at a place reasonably convenient for the worker. If the worker fails to attend for the examination or obstructs the medical examiner, the worker's right to compensation is suspended until the examination has taken place, and no compensation is payable during the period of suspension.

(2) The Board may reduce or suspend compensation when the worker

(a) persists in insanitary or injurious practices which tend to imperil or retard his or her recovery; or

(b) refuses to submit to medical or surgical treatment which the Board considers, based on expert medical or surgical advice, is reasonably essential to promote his or her 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 award 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 57(1) of the *Act* suspends a worker's right to compensation on a claim if the worker fails to attend or obstructs a medical examination. 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 term "medical examination" 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).

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 he or she would not be attending.

In determining whether a worker has obstructed a medical examination, 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 or obstructing an examination, the Board takes the following actions:

(a) The Board determines whether the worker has failed to attend or has obstructed an examination.

(b) If the Board determines the worker has failed to attend or has obstructed an examination, 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 57(1) 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 INSANITARY OR INJURIOUS PRACTICES

The Board has discretion under section 57(2)(a) of the *Act* to determine whether and how a worker's compensation may be affected by the worker's persistence in insanitary or injurious practices that tend to imperil or retard 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 or permanent disability award payment on that claim.

Before the Board reduces or suspends a worker's compensation for persisting in insanitary or injurious practices, the Board takes the following actions:

(a) The Board determines whether the worker is engaging in an insanitary or injurious practice that tends to imperil or retard 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 insanitary 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 insanitary 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 or permanent disability award 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 57(2)(a) of the *Act*, the worker must satisfy the Board that the insanitary 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 insanitary 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 insanitary 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 57(2)(b) of the *Act* to reduce or suspend a worker's compensation where the worker refuses to submit to medical or surgical treatment that the Board considers, based on medical 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 wage-loss and/or health care 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 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 or permanent disability award

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 57(2)(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 57 of the *Act*.
CROSS REFERENCES:	Policy item #34.54, *When is the Worker's Condition Stabilized*; Policy item #34.55, *Subsequent Non-Compensable Incidents*; Policy item #35.30, *Duration of Temporary Disability 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*; Policy item #93.26, *Obligation to Provide Information*; Policy item #93.30, *Medical Treatment and Examination*; Item C14-102.01, *Changing Previous Decisions – Reopenings*; and Item C14-104.01, *Changing Previous Decisions – Fraud and Misrepresentation*.
HISTORY:	This policy incorporates concepts from former policy item #73.30, and consolidates and replaces 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 21:

(1) See Item C10-72.00.

…

(6) See Item C10-73.00.

Section 56(3):

Unless the Board otherwise directs, an account for medical services or health care must not be paid if it is submitted later than 90 days from the date that

(a) the last treatment was given; or

(b) the physician or person furnishing the medical service was first aware that the Board may be liable for his or her services,

whichever first occurs.

POLICY

1. DEFINITIONS

As set out in Item C10-72.00, *Health Care – Introduction*, "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 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 his or her 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 his or her 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); or
- 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.

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 rendered 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 suffer from 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 rendered 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 rendered 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:	January 1, 2015
AUTHORITY:	Sections 21 and 56 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*; Policy item #95.00, *Responsibilities of Physicians/Qualified Practitioners*; Policy item #95.10, *Form of Reports*; Policy item #95.20, *Reports by Specialists*; Policy item #95.30, *Failure to Report*; Policy item #95.40, *Obligation to Advise and Assist Worker*; Policy item #96.21, *Preliminary Determinations*; *and* Policy item #99.20, *Notification of Decisions.*
HISTORY:	This policy consolidates and replaces former policy items #73.10, #76.20, #78.30, #78.31, #78.32, and incorporates 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:	This Item applies on or after January 1, 2015.

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 8(1):

> Where the injury of a worker occurs while the worker is working elsewhere than in the Province which would entitle the worker or the worker's dependants to compensation under this Part if it occurred in the Province, the Board must pay compensation under this Part if
>
> (a) a place of business of the employer is situate in the Province;
>
> (b) the residence and usual place of employment of the worker are in the Province;
>
> (c) the employment is such that the worker is required to work both in and out of the Province; and
>
> (d) the employment of the worker out of the Province has immediately followed the worker's employment by the same employer within the Province and has lasted less than 6 months,
>
> but not otherwise.

Section 8.1:

> (1) The Board may enter into an agreement or make an arrangement with Canada, a province or the appropriate authority of Canada or a province to provide for
>
> (a) compensation, rehabilitation and health care to workers in accordance with the standards established under this *Act* or corresponding legislation in other jurisdictions,

(b) administrative co-operation and assistance between jurisdictions in all matters under this *Act* and corresponding legislation in other jurisdictions, or

(c) avoidance of duplication of assessments on workers' earnings.

(2) An agreement or arrangement under subsection (1) may

(a) waive or modify a residence or exposure requirement for eligibility for compensation, rehabilitation or health care, or

(b) provide for payment to the appropriate authority of Canada or a province for compensation, rehabilitation costs, or health care costs paid by it.

Section 21:

(1) See Item C10-72.00.

…

(6) See Item C10-73.00;

Section 57.1:

(1) A worker who applies for or is receiving compensation 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.

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 disorder. 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 8.1 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 the province, 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, *Reduction or Suspension of Compensation*, are met.

EFFECTIVE DATE:	January 1, 2015
AUTHORITY:	Sections 8, 8.1, 21 and 57.1 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*; and Policy item #93.26, *Obligation to Provide Information.*
HISTORY:	This policy incorporates the concepts from and replaces 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:

> "physician" means a person authorized under an enactment to practise in British Columbia as a medical practitioner;
>
> "qualified practitioner" means a person authorized under an enactment to practise in British Columbia as a chiropractor, a dentist, a naturopathic physician, a nurse practitioner or a podiatrist;
>
> "specialist" means a physician residing and practising in the Province and listed by the Royal College of Physicians and Surgeons of Canada as having specialist qualifications;

Section 21:

> (1) See Item C10-72.00.
>
> (2) See Item C10-73.00.
>
> …
>
> (6) See Item C10-73.00.
>
> (7) See Item C10-73.00.
>
> (8) The Board may assume the responsibility of replacement and repair of
>
> …
>
> (b) eyeglasses, dentures and hearing aids broken as a result of an accident arising out of and in the course of employment …

Section 56:

(1) It is the duty of every physician or qualified practitioner attending or consulted on a case of injury to a worker, or alleged case of injury to a worker, in an industry within the scope of this Part

. . .

(d) to give all reasonable and necessary information, advice and assistance to the injured worker and the worker's dependants in making application for compensation, and in furnishing in connection with it the required certificates and proofs, without charge to the worker.

(2) Every physician or qualified practitioner who is authorized by this *Act* to treat an injured worker is subject to like duties and responsibilities, and any health care furnished by the physician or qualified practitioner is subject to the direction, supervision and control of the Board.

…

(4) A physician, qualified practitioner or other person authorized to render health care under this Part must confine his or her treatment to injuries to the parts of the body he or she is authorized to treat under the statute under which he or she is permitted to practise, and the giving of any unauthorized treatment is an offence against this Part.

(5) A physician, qualified practitioner or other person who fails to submit prompt, adequate and accurate reports and accounts as required by this *Act* or the Board commits an offence against this Part, and his or her right to be selected by a worker to render health care may be cancelled by the Board, or he or she may be suspended for a period to be determined by the Board. When the right of a person to render health care is so cancelled or suspended, the Board must notify the person of the cancellation or suspension, and must likewise inform the governing body named in the *Act* under which the person is authorized to treat human ailments, and the person whose right to render health care is cancelled or suspended must also notify injured workers who seek treatment from the person of the cancellation or suspension.

3. Health Professions Act

Section 12(1):

> The Lieutenant Governor in Council may, by regulation, designate a health profession for the purposes of this Act.

Section 15(1):

> On designation of a health profession under section 12 (1), a college responsible for carrying out the objects of this Act in respect of the health profession is established.

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. 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, *Direction, Supervision, and Control of Health Care*.

Physicians and qualified practitioners are confined to treat injuries to the parts of the body they are authorized by their governing statutes, regulations and bylaws to treat.

The Board may further limit the injuries and parts of the body they are authorized to treat. The provision of any unauthorized treatment is an offence. The maximum fine for committing this offence is set out in Appendix 6 to this *Manual*.

The Board will not pay for a worker to attend a physician or qualified practitioner whose right to render health care has been cancelled or suspended either by the licensing body, or by the Board under the provisions referred to in policy item #95.30, *Failure to Report*.

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 all reasonable and necessary information, advice and assistance to workers and their dependants in making an application for compensation.

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 recognised 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, *Direction, Supervision, and Control of Health Care*, 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, *Health Care Accounts – General*.

3.2 Psychiatric Consultation and Treatment

A psychiatrist is one type of specialist physician. "Psychiatrist" means a physician who is recognized by the College of Physicians and Surgeons of British Columbia, or another accrediting body recognized by the Board, as being a specialist in psychiatry.

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

Registered members in good standing with the College of Chiropractors of British Columbia may provide chiropractic treatment and services to injured workers. Chiropractors may provide the chiropractic treatment and services authorized by the *Health Professions 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

Registered members in good standing with the College of Dental Surgeons of British Columbia may provide dental treatment and services to injured workers. Dentists may provide the dental treatment and services authorized by the *Health Professions 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 21(8)(b) of the *Act* and Item C3-23.20, *Section 21(8)(b) – Eyeglasses, Dentures and Hearing Aids*.

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

Registered members in good standing with the British Columbia Association of Podiatrists may provide podiatric treatment and services to injured workers. Podiatrists may provide the podiatric treatment and services authorized by the *Health Professions 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

Registered members in good standing with the College of Naturopathic Physicians of British Columbia may provide naturopathic treatment and services to injured workers. Naturopathic physicians may provide the naturopathic treatment and services authorized by the *Health Professions 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 disorder. 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 does not pay health care accounts for naturopathic remedies, treatments, or dietary supplements without prior Board approval of the naturopathic physician's proposed remedy, treatment, or supplement.

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 College of Registered Nurses of British Columbia may provide nursing treatment and services to injured workers. Nurse practitioners may provide the nursing treatment and services authorized by the *Health*

Professions 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:	January 1, 2015
AUTHORITY:	Sections 1, 21 and 56 of the *Act*.
CROSS REFERENCES:	Sections 12 and 15 of the *Health Professions Act*, RSBC 1996, c 183; Item C3-23.00, *Replacement and Repair of Personal Possessions – Section 21(8)*; Item C3-23.20, *Section 21(8)(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*; Policy item #95.00, *Responsibilities of Physicians/Qualified Practitioners*; Policy item #95.10, *Form of Reports*; Policy item #95.20, *Reports by Specialist*; Policy item #95.30, *Failure to Report*; Policy item #95.40, *Obligation to Advise and Assist Worker*; and Appendix 6, *Maximum Fines for Committing Offences Under the Act.*
HISTORY:	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 Bill 17. This policy consolidates and replaces 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 includes 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 section 5.1(1) of the *Act* and the introduction of section 5.1(2) to (4) of the *Act.* March 3, 2003 – consequential changes as to references to review.
APPLICATION:	This Item applies to health care expenses incurred and health care provided on or after January 1, 2015.

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 21:

(1) See Item C10-72.00.

…

(6) See Item C10-73.00.

…

(8) See Item C10-76.00.

Section 56:

…

(4) See Item C10-76.00.

3. Health Professions Act

Section 12(1):

> The Lieutenant Governor in Council may, by regulation, designate a health profession for the purposes of this Act.

Section 15(1):

> On designation of a health profession under section 12 (1), a college responsible for carrying out the objects of this Act in respect of the health profession is established.

POLICY

1. DEFINITION

As set out in Item C10-72.00, *Health Care – Introduction,* "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 to the parts of the body they are authorized by their governing statutes, regulations and bylaws to treat. The Board may further limit the injuries and parts of the body they are authorized to treat. The provision of any unauthorized treatment is an offence. The maximum fine for committing this offence is set out in Appendix 6 to this *Manual*.

The Board does not pay for a worker to attend other recognized health care professionals whose rights to render health care have been cancelled or suspended either by the licensing body, or by the Board under the provisions referred to in policy item #95.30, *Failure to Report*.

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

Registered members in good standing with the College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia may provide acupuncture treatment and services to injured workers. Acupuncturists may provide the acupuncture treatment and services authorized by the *Health Professions 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 may not pay for acupuncture treatment until it has received and approved a request from the acupuncturist outlining details such as the number of treatments expected, the treatment plan and the expected outcome.

The Board's approval of acupuncture treatment includes direction on the number of authorized treatment visits. In most cases, the Board limits payment to a maximum of five treatment visits over a two-week period from the date of the injured worker's first visit, unless otherwise stated in any current Board contract and/or fee schedule in place at the time of service delivery.

5. AUDIOLOGISTS

Registered members in good standing with the College of Speech and Hearing Health Professionals of British Columbia may provide audiology services to injured workers. Audiologists may provide the audiology services authorized by the *Health Professions*

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 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. COMMUNITY HEALTH WORKERS

Community health workers include residential care aides, personal care attendants, registered care attendants, home support workers, rehabilitation aides, or nurses' aides. Community health workers work under the direction and supervision of a physician, nurse practitioner, registered nurse or licensed practical nurse.

Where appropriate, the Board may pay health care accounts for community health workers to provide injured workers with treatments such as home wound care services or home intravenous therapy services. The Board administers these services pursuant to any current Board contract and/or fee schedule in place at the time of service delivery.

7. DENTURISTS

Registered members in good standing with the College of Denturists of British Columbia may provide denturist services to injured workers. Denturists may provide the denturist services authorized by the *Health Professions 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 pays reporting or form fees to denturists for any reports that the Board requires, and 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

Registered members in good standing with the College of Dietitians of British Columbia may provide dietetic services to injured workers. Dietitians may provide the dietetic

services authorized by the *Health Professions 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 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

Registered members in good standing with the College of Massage Therapists of British Columbia may provide massage therapy treatment and services to injured workers. Massage therapists, registered massage therapists, massage practitioners, and registered massage practitioners may provide the massage therapy treatment and services authorized by the *Health Professions 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.

In most cases, the Board limits payment to a maximum of three treatment visits per week up to five weeks from the date of the injured worker's first visit, unless otherwise stated in any current Board contract and/or fee schedule in place at the time of service delivery. The Board may pay for extensions of massage therapy treatments beyond five weeks based on a review of the evidence.

The Board does not pay for more than one massage therapy treatment per day.

10. NURSES

Registered nurses in good standing with the College of Registered Nurses of British Columbia, and licensed practical nurses in good standing with the College of Licensed Practical Nurses of British Columbia, may provide nursing treatment and services to injured workers. Nurses may provide the nursing treatment and services authorized by the *Health Professions 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.

Where appropriate, the Board may pay health care accounts for nurses to provide injured workers with treatments such as home wound care services or home intravenous therapy services. The Board administers these services pursuant 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

Registered members in good standing with the College of Occupational Therapists of British Columbia 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 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 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

Registered members in good standing with the College of Opticians of British Columbia may provide opticianry services to injured workers. Opticians, dispensing opticians and contact lens fitters may provide the opticianry services authorized by the *Health Professions 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 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

Registered members in good standing with the College of Optometrists of British Columbia may provide optometry treatment and services to injured workers. Optometrists may provide the optometry treatment and services authorized by the *Health Professions 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 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

Registered members in good standing with the College of Pharmacists of British Columbia may provide pharmacy services to injured workers. Pharmacists may provide the pharmacy services authorized by the *Health Professions 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 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

Registered members in good standing with the College of Physical Therapists of British Columbia may provide physical therapy treatment and services to injured workers. Physical therapists, registered physical therapists, physiotherapists, registered physiotherapists, remedial gymnasts and registered remedial gymnasts may provide the physical therapy treatment and services authorized by the *Health Professions 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.

In most cases, the Board limits payment to a maximum of one visit per day up to eight weeks, or 22 visits, whichever is earlier, from the date of the injured worker's first visit, unless otherwise stated in any current Board contract and/or fee schedule in place at the time of service delivery. The Board may pay for extensions of physical therapy treatments and services beyond eight weeks or 22 visits based on a review of the evidence.

16. PROSTHETISTS AND ORTHOTISTS

Registered members in good standing with the Canadian Board for Certification of 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 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

Registered members in good standing with the College of Psychologists of British Columbia may provide psychological treatment and services to injured workers. Psychologists, registered psychologists, psychological associates and registered psychological associates may provide psychological treatment and services as authorized by the *Health Professions 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 British Columbia Association of Clinical Counsellors, or Canadian certified counsellors in good standing with the Canadian Counselling and Psychotherapy Association, 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 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 the Board's Agreement for Mental Health Providers for Psychology Assessment Services, the Mental Health Treatment Service Agreement, and accompanying guidelines.

EFFECTIVE DATE:	January 1, 2015
AUTHORITY:	Sections 21 and 56 of the *Act*.
CROSS REFERENCES:	Sections 12 and 15 of the *Health Professions Act*, RSBC 1996, c 183; 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*; and Appendix 6, *Maximum Fines for Committing Offences Under the Act.*

HISTORY:	Housekeeping changes made on January 1, 2018 as a result of the amendment of section 15(1) of the *Act*, effective November 2, 2017. January 1, 2015 – Policy amended to remove reference to nurse practitioners as other recognized health care professionals. This policy incorporates the concepts from and replaces 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 includes 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 January 1, 2015.

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 21:

(1) See Item C10-72.00.

(2) See Item C10-73.00.

…

(6) See Item C10-73.00.

POLICY

1. GENERAL

As set out in Item C10-72.00, *Health Care – Introduction*, "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 his

or her 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 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, *Reduction or Suspension of Compensation* are met.

EFFECTIVE DATE:	January 1, 2015
AUTHORITY:	Section 21 of the *Act*.
CROSS REFERENCES:	Policy item #49.10*, Worker Receiving Custodial Care in Hospital*; 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*; and Item C10-79.00, *Health Care Supplies and Equipment*.
HISTORY:	This policy consolidates and replaces 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 16:

(1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

(2) Where compensation is payable under this Part as the result of the death of a worker, the Board may make provisions and expenditures for the training or retraining of a surviving dependent spouse, regardless of the date of death.

(3) The Board may, where it considers it advisable, provide counselling and placement services to dependants.

Section 21:

(1) See Item C10-72.00.

...

(9) Where an injury to a worker results in serious impairment of the worker's sight, the Board may, to protect 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 it considers reasonably necessary to cure and relieve and/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 relieve the worker from 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, sedative/hypnotic, and other potentially addictive drugs are discussed in Item C10-80.00, *Potentially Addictive Drugs*.

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 loss of hearing 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 his or her 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 his or her 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 16 and 21 of the *Act*.
CROSS REFERENCES:	Item C3-23.00, *Replacement and Repair of Personal Possessions – Section 21(8)*; 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*; *and* Chapter 11 – Vocational Rehabilitation.
HISTORY:	This policy consolidates concepts and replaces 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 21:

(1) See Item C10-72.00.

...

(6) 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, 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, sedative/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 SEDATIVE/HYPNOTICS

The Board may pay for prescribed sedative/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 his or her 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:	Section 21 of the *Act*.
CROSS REFERENCES:	Item C10-79.00, *Health Care Supplies and Equipment*; and Practice Directive C10-1, *Claims with Opioids, Sedatives – Hypnotics or Other Drugs of Addiction Prescribed.*
HISTORY:	This policy replaces 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 21:

(1) See Item C10-72.00.

...

(6) 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 his or her 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, *Additional Benefits for Severely Disabled Workers*.

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 he or she 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, *Additional Benefits for Severely Disabled Workers*.

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:	Section 21 of the *Act*.
CROSS REFERENCES:	Policy item #48.40, *Overpayments/Money Owed to the Board*; Item C10-79.00, *Health Care Supplies and Equipment*; and

	Item C10-84.00, *Additional Benefits for Severely Disabled Workers*.
HISTORY:	This policy replaces 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 21:

(1) 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, 2018 – Dec. 31, 2018	Jan. 1, 2019 – Dec. 31, 2019
Upper Limb	$348.83	$357.36
Lower Limb	$699.37	$716.47
Bilateral Limb	$699.37	$716.47
Upper and Lower Limb	$1,048.32	$1,073.95

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 October of the previous year with the consumer price index 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 award 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 21 of the *Act.*
CROSS REFERENCES:	C10-79.00, *Health Care Supplies and Equipment*; *and* C10-84.00, *Additional Benefits for Severely Disabled Workers.*

HISTORY:

January 2018 – Policy 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.
This policy replaces former policy item #79.00 of the *Rehabilitation Services & Claims Manual,* Volume II.
October 1, 2007 – 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 21:

(1) See Item C10-72.00.

…

(3) … Every employer must, at the employer's own expense, furnish to a worker injured in the employer's employment, when necessary, immediate conveyance and transportation to a hospital, physician or qualified practitioner for initial treatment.

…

(7) See Item C10-73.00.

POLICY

1. DEFINITIONS

As set out in Item C10-72.00, *Health Care – Introduction*, "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, *Direction, Supervision, and Control of Health Care*, 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 his or her resident community, and the worker's disability from the compensable personal injury, occupational disease or mental disorder prevents the worker from returning to his or her place of residence using his or her 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 21(3)); 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 the province. This does not apply where the Board specifically requests the worker to attend a medical examination, or in certain situations specified in policy item #100.15, *Worker Resides Outside the Province*, 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 his or her 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 his or her 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 insanitary or injurious practice, and therefore reduce or suspend the worker's compensation, if the circumstances in Item C10-74.00, *Reduction or Suspension of Compensation*, 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 where:

(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 where 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 where 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 where:

(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, 2018 – December 31, 2018	43¢
January 1, 2019 – December 31, 2019	44¢

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

Effective June 30, 2002, the Board adjusts the mileage rate annually on January 1st of each year using the percentage change in the consumer price index, rounded to the nearest cent.

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 his or her 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 his or her 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:	January 1, 2015
AUTHORITY:	Section 21 of the *Act*.
CROSS REFERENCES:	Policy item #48.40, *Overpayments/Money Owed to the Board*; Policy item #51.20, *Dollar Amounts in the Act*; 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;* and Policy item #100.00, *Reimbursement of Expenses*.
HISTORY:	This policy incorporates the concepts from and replaces 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 January 1, 2015.

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:

> "dependant" means a member of the family of a worker who was wholly or partly dependent on the worker's earnings at the time of the worker's death, or who but for the incapacity due to the accident would have been so dependent…
>
> "member of family" means
>
> (a) a spouse, parent, grandparent, stepparent, child, grandchild, stepchild, sibling or half sibling, and
>
> (b) a person who stood in the place of a parent to the worker or to whom the worker stood in place of a parent, whether related to the worker by blood or not;

Section 5(2):

> See Item C10-72.00.

Section 21(1):

> See Item C10-72.00.

Section 34:

> (1) In fixing the amount of a periodic payment of compensation, consideration must be had to payments, allowances or benefits which the worker may receive from the worker's employer during the period of the disability, including a pension, gratuity or other allowance provided wholly at the expense of the employer, and a sum deducted under this section from the compensation otherwise payable may be paid to the employer out of the accident fund.

(2) Subject to sections 7(4.1), 22(2) and 23(4), the Board must deduct, from the amount of a periodic payment of compensation paid to a worker under section 22(1) or 23(1) or (3) for an injury, an amount equal to 50% of any disability benefit that the worker is paid in respect of the injury under the *Canada Pension Plan*.

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, *Health Care – Introduction*, "residence" means the place where a worker lives or regularly stays. Where a 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 his or her 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 his or her 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 insanitary or injurious practice, and therefore reduce or suspend the worker's compensation, if the circumstances in Item C10-74.00, *Reduction or Suspension of Compensation*, 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 his or her 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 his or her 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 his or her 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, 2018 – December 31, 2018	$13.17	$16.25	$27.96	$57.38
January 1, 2019 – December 31, 2019	$13.49	$16.65	$28.64	$58.78

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.

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 wage-loss compensation, the Board applies the provisions of section 5(2) 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 34 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 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 where 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, 5, 21, 25 and 34 of the *Act*.
CROSS REFERENCES:	Policy item #34.20, *Minimum Amount of Compensation*; Policy item #51.20, *Dollar Amounts in the* Act*;* Policy item #68.22, *Room and Board;* Policy item #69.00, *Maximum Amount of Average Earnings; and* Item *C10-84.00, Additional Benefits for Severely Injured Workers.*
HISTORY:	This policy incorporates the concepts from and replaces 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:

> "member of family" means
>
> (a) a spouse, parent, grandparent, stepparent, child, grandchild, stepchild, sibling or half sibling, and
>
> (b) a person who stood in the place of a parent to the worker or to whom the worker stood in place of a parent, whether related to the worker by blood or not;

Section 21(1):

> … the Board may furnish or provide for the injured worker any … other care … that it may consider reasonably necessary at the time of the injury, and thereafter during the disability to cure and relieve from the effects of the injury or alleviate those effects…

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 him or her); 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 he or she 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 he or she is receiving health care in a health care facility away from his or her resident community where:

- a worker is participating in a Board-approved health care program that requires the worker to live elsewhere than his or her 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 he or she 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, *Transportation*, and Item C10-83.10, *Subsistence Allowances*.

EFFECTIVE DATE:	January 1, 2015
AUTHORITY:	Sections 1 and 21 of the *Act*.
CROSS REFERENCES:	Item C10-83.00, *Transportation;* Item C10-83.10, *Subsistence Allowances;* Policy item #97.30, *Medical Evidence*; and Policy item #97.31, *Matter Requiring Medical Expertise*.
HISTORY:	This policy incorporates concepts from and replaces 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 21(3):

> See Item C10-83.00.

3. *Workers Compensation Act*, Fishing Industry Regulations

Section 13:

> For the purposes of section 21(3) of Part 1, the expense of transporting an injured fisher to a hospital, physician or other qualified practitioner for initial treatment shall 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 employer'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 21 of the *Act*.
CROSS REFERENCES:	Section 13 of the *Fishing Industry Regulations*, B.C. Reg. 674/76.
HISTORY:	This policy replaces 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 16:

(1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

. . .

(3) The Board may, where it considers it advisable, provide counselling and placement services to dependants.

Section 21:

(1) See Item C10-72.00.

(6) See Item C10-73.00.

Section 23.5:

(1) If a worker has a permanent total disability, the Board must assess, within the 3 month period before the retirement benefit is payable to the worker, the need or continued need of the worker for services and personal supports under sections 16 and 21.

(2) After the assessment under subsection (1) is completed, the Board must take all actions necessary to provide to the worker, for his or her life, the services and personal supports under sections 16 and 21 that the Board considers are 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 sections 16 and 21.

POLICY

1. DEFINITIONS

The following terms are used throughout this policy.

As set out in Item C10-72.00, *Health Care – Introduction*, "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 medications.

An "informal caregiver" is a family member or friend who assists a severely disabled worker at home with his or her care and activities of daily living.

As set out in C10-72.00, *Health Care – Introduction*, "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, and/or driving a car.

2. OBJECTIVE

The Board may pay for various additional health care 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 23(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 where:

- 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 his or her 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 their 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 himself or herself.

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 himself or herself 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 him or herself.

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, 2018 – December 31, 2018					
Daily Amount	$17.69	$30.13	$44.83	$58.05	$71.59
Monthly Amount	$532.51	$931.62	$1,345.62	$1,744.74	$2,144.38
January 1, 2019 – December 31, 2019					
Daily Amount	$18.12	$30.87	$45.93	$59.47	$73.34
Monthly Amount	$545.53	$954.39	$1,378.52	$1,787.39	$2,196.80

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.

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 his or her 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, *Home and Vehicle Modifications*.

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 a sum 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 relieve from or 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 his or her 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, *Home and Vehicle Modifications*. 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 other's 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 a sum 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 other's 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, wage-loss payments, or permanent disability award 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 his or her 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 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.

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

Date	Monthly Amount
January 1, 2018 – December 31, 2018	$311.92
January 1, 2019 – December 31, 2019	$319.55

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, *Physicians and Qualified Practitioners*, and C10-77.00, *Other Recognized Health Care Professionals*, 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, preventive, 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 16, 21 and 23.5 of the *Act*.
CROSS REFERENCES:	Policy item #48.40, *Overpayments/Money Owed to the Board;* Policy item #49.10, *Worker Receiving Custodial Care in Hospital*; Policy item #49.11, *Meaning of Custodial Care in Hospital or Elsewhere in Section 35(5)*; Policy item #49.13, *Application of Section 35(5) in Cases of Temporary Disability*; Policy item #49.14, *Application of Section 35(5) in Cases of Permanent Disability*; Policy item #49.15, *Application of Section 35(5) on a Change of Circumstances*; Policy item #51.20, *Dollar Amounts in the Act*; 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*; and Chapter 11 – Vocational Rehabilitation.
HISTORY:	This policy consolidates and replaces former policy items #80.00, #80.10, #80.20, and #81.00, and incorporates 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 16:

(1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

(2) Where compensation is payable under this Part as the result of the death of a worker, the Board may make provisions and expenditures for the training or retraining of a surviving dependent spouse, regardless of the date of death.

(3) The Board may, where it considers it advisable, provide counselling and placement services to dependants.

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.

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 is suffering from a compensable injury or disease together with some other impediment to a return 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 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 return a worker to work with the pre-injury employer in a selective/light employment, a graduated return to work or a modified return to 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 30 of the *Act,* which refers to an assessment of what a worker is earning or is capable of earning in a suitable occupation.

3. For workers entitled to a permanent partial disability award, 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 a permanent total disability award, the goal is to assist in improving quality of life and minimizing the impact of the disability.

5. For surviving spouses and dependants of deceased workers, the goal is to provide counselling and vocational assistance 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
- assessment 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.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	September 1, 2015
AUTHORITY:	Section 16 of the *Act*.
CROSS REFERENCES:	Sections 22, 23, 29 and 30 of the *Act;* Item C11-91.00, *Vocational Rehabilitation – Vocational Assistance for Surviving Spouses and Dependants of Deceased Workers*; and Item C18-116.30, *Retirement Benefits – Retirement Services and Personal Supports* of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	September 1, 2015 – Policy revisions to ensure consistent treatment of workers with permanent partial disability awards under sections 23(1) and 23(3) of the *Act.* June 1, 2009 – Deleted references to Vocational Rehabilitation Services. November 1, 2002 – Policy changes 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 *Act,* 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 - Eligibility Criteria	ITEM: C11-86.00

BACKGROUND

1. Explanatory Notes

This policy sets out eligibility criteria for vocational rehabilitation services.

2. The Act

Section 16:

(1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation. ….

Section 22:

(1) … if a permanent total disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment that equals 90% of the worker's average net earnings.
….

Section 29:

(1) … if a temporary total disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment that equals 90% of the worker's average net earnings. ….

Section 30:

(1) … if a temporary partial disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment 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 23:

(1) Subject to subsections (3) to (3.2) …, if a permanent partial disability results from a worker's injury, the Board must

(a) estimate the impairment of earning capacity from the nature and degree of the injury, and

(b) pay the worker compensation that is a periodic payment that equals 90% of the Board's estimate of the loss of average net earnings resulting from the impairment. …

(3) … if

(a) a permanent partial disability results from the a worker's injury, and

(b) the Board makes a determination under subsection (3.1) with respect to the worker,

the Board may pay the worker compensation that is a periodic payment that equals 90% of the difference between

(c) the average net earnings of the worker before the injury, and

(d) 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.

(3.1) A payment may be made under subsection (3) only if the Board determines that the combined effect of the worker's occupation at the time of the injury and the worker's disability resulting from the injury is so exceptional that an amount determined under subsection (1) does not appropriately compensate the worker for the injury.

(3.2) In making a determination under subsection (3.1), the Board must consider the ability of the worker to continue in the worker's occupation at the time of the injury or to adapt to another suitable occupation.

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 or in making selective/light employment 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 a 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 a suitable occupation;
- the pre-injury job is no longer available due to the injury and the worker requires assistance to return to work in a suitable occupation.

Permanent partial disability (section 23(1))

Vocational rehabilitation services may be provided where a worker's temporary disability has ceased and his or her medical condition has stabilized. Workers with a section 23(1) award 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 his or her 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 his or her efforts to return to the pre-injury occupation or another suitable occupation;
- the pre-injury job is no longer available due to the injury and the worker requires assistance to return to another suitable occupation.

Permanent partial disability (section 23(3))

Vocational rehabilitation services may be provided to a worker who is entitled to a section 23(3) assessment for permanent partial disability and the worker requires assistance in his or her 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 his or her quality of life. It may include assessment 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 is suffering from 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 wage-loss compensation is concluded. The worker may no longer be eligible for temporary disability benefits, but vocational assistance may still be required and, where necessary, should be provided.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	June 1, 2009 – Delete reference to Board officer in Vocational Rehabilitation Services.
AUTHORITY:	ss. 16, 22, 23, 29, 30 and 96.2 of the *Act*.
CROSS REFERENCES:	Selective/Light Employment (policy item #34.11), Vocational Rehabilitation - Referral Guidelines (Item C11-86.10), Injury Not Caused by Worker or Employer (policy item #111.20), and Retirement Benefits - Retirement Services and Personal Supports (Item C18-116.30) of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	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 on or after June 1, 2009

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 16:

> (1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it 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 30 of the *Act*.

3. Employability assessments for the consideration of permanent partial disability under section 23(3).

4. Consideration for continuity of income benefits.

5. Commutation investigations.

6. Reviews under section 24.

7. Consideration of a permanently totally disabled worker's need or continued need for rehabilitation and 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.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	September 1, 2015
AUTHORITY:	Section 16 of the *Act*.
CROSS REFERENCES:	ss. 21, 22, 23, 24 and 30 of the *Act;* and Policy item #35.11*, Procedure for Determining Whether Worker is Temporary Partially Disabled*; Policy item #40.10, *Section 23(3) Assessment Formula*; Policy #40.12, *Suitable Occupation*; Policy item #45.50, *Decision-Making Procedures*; Policy item #46.00, *Review of Old Pensions under Section 24*; Policy item #80.00, *Personal Care Expenses or Allowances*; Policy item #81.00, *Independence and Home Maintenance Allowance*; Policy item #84A.00, *Homemakers Services*; Item C11-86.00, *Vocational Rehabilitation – Eligibility Criteria*; Item C11-89.00, *Vocational Rehabilitation – Employability Assessments – Temporary Partial Disability and Permanent Partial Disability*; and Item C18-116.30, *Retirement Benefits – Retirement Services and Personal Supports* of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	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 a 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 *Act,* 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 Process	ITEM: C11-87.00

BACKGROUND

1. Explanatory Notes

This policy sets out the vocational rehabilitation process.

2. The Act

Section 16:

> (1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it 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.

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.

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.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officers.
AUTHORITY:	Section 16 of the *Act*.
CROSS REFERENCES:	Vocational Rehabilitation - Principles and Goals (Item C11-85.00), Vocational Rehabilitation - Nature and Extent of Programs and Services (Item C11-88.00), Vocational Rehabilitation - Work Assessments (Item C11-88.10), Vocational Rehabilitation - Work Site and Job Modification (Item C11-88.20), Vocational Rehabilitation - Job Search Assistance (Item C11-88.30), Vocational Rehabilitation - Training-on-the-Job (Item C11-88.40), Vocational Rehabilitation - Formal Training (Item C11-88.50), Vocational Rehabilitation - Business Start-ups (Item C11-88.60), Vocational Rehabilitation - Legal Services (Item C11-88.70), Vocational Rehabilitation - Preventative Rehabilitation (Item C11-88.80), and Vocational Rehabilitation - Relocation (Item C11-88.90) of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	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 *Act*, as amended by the *Workers Compensation Amendment Act, 2002*.

APPLICATION: Applies on or after June 1, 2009

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 16:

> (1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it 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 his or her own vocational future.

Application of the Vocational Rehabilitation Process

The vocational rehabilitation process is generally applicable as follows:

Temporary total disability under section 29 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 or selective light duties with pre-injury employer.

Temporary partial disability under section 30 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 23 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 22 of the *Act* – Quality of life assistance may include vehicle modifications, home modifications, personal care allowances, independence and home maintenance allowances and homemakers' services.

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 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 and unanticipated 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 in relation to the applicable phase of benefit entitlement;
- the worker fails to cooperate with 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 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 awards. These benefits may apply while workers are either awaiting or undertaking specific vocational programs.

Transportation 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.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	September 1, 2015
AUTHORITY:	Section 16 of the *Act*.
CROSS REFERENCES:	Sections 22, 23 and 29 and 30 of the *Act;* Chapter 9 Average Earnings; Policy item #34.11, *Selective/Light Employment*; Policy item #69.10, *Deduction of Permanent Disability Periodic Payments from Wage Loss*; Policy item #70.30, *Permanent Disability Awards*; Item C10-83.00, *Transportation Allowances*; Item C10-83.10, *Subsistence Allowances*; Item C11-85.00, *Vocational Rehabilitation – Principles and Goals*; Item C11-87.00, *Vocational Rehabilitation – Process*;

Item C11-90.00, *Vocational Rehabilitation – Spinal Cord and Other Severe Injuries*; and
Policy item #97.30, *Medical Evidence* of the *Rehabilitation Services & Claims Manual*, Volume II.

HISTORY: 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 awards under section 23(1) and 23(3) 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 include 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 *Act*, 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 Work Assessments	ITEM: C11-88.10

BACKGROUND

1. Explanatory Notes

This policy describes work assessment programs.

2. The Act

Section 16:

(1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it 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 C11-88.00, "Nature and Extent of Programs and Services", 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 29 or 30 of the *Act*, or payment of rehabilitation allowances under section 16 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.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	November 1, 2002.
AUTHORITY:	Section 16 of the *Act*.
CROSS REFERENCES:	Sections 29 and 30 of the *Act;* Vocational Rehabilitation - Process (Item C11-87.00) and Vocational Rehabilitation - Nature and Extent of Programs and Services (Item C11-88.00) of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	Replaces 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 *Act*, as amended by the *Workers Compensation Amendment Act, 2002*.

RE: Vocational Rehabilitation — Work Site and Job Modification **ITEM: C11-88.20**

BACKGROUND

1. Explanatory Notes

This policy describes work site and job modification programs.

2. The Act

Section 16:

(1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation. ….

POLICY

Work Site and Job Modification

The Board may provide assistance to alter work sites or modify jobs to facilitate re-employment in physically appropriate working conditions.

Guidelines

Subject to policy C11-88.00, "Nature and Extent of Programs and Services", 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.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	November 1, 2002
AUTHORITY:	Section 16 of the *Act*.
CROSS REFERENCES:	Vocational Rehabilitation - Process (Item C11-87.00) and Vocational Rehabilitation - Nature and Extent of Programs and Services (Item C11-88.00) of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	Replaces policy items #88.20, #88.21, and #88.22 of the *Rehabilitation Services & Claims Manual*, Volume II.
APPLICATION:	To decisions made on or after November 1, 2002 on claims adjudicated under the *Act*, as amended by the *Workers Compensation Amendment Act, 2002*.

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 16:

(1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it 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 C11-88.00, "Nature and Extent of Programs and Services", 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 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.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	September 1, 2015
AUTHORITY:	Section 16 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*; and Item C11-88.90, *Vocational Rehabilitation – Relocation* of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	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 are also provided for granting extensions. Replaces 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 *Act*, 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 16:

(1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it 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 C11-88.00, "Nature and Extent of Programs and Services", 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 result in no loss of earnings for a worker who is being assessed for a section 23(3) award;
   - 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 temporary disability 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 33(10) 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. Disability awards 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 39(1)(e).

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	September 1, 2015
AUTHORITY:	Section 16 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*; Policy item #114.40A*, Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*; and Policy item #115.30, *Experience Rating* of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	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. Replaces Items #88.40 - #88.43 of the *Rehabilitation Services & Claims Manual*, Volume II. Applies to decisions made on or after November 1, 2002 on claims adjudicated under the *Act*, 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 Formal Training	ITEM:	C11-88.50

BACKGROUND

1. Explanatory Notes

This policy sets out the Board's formal training program.

2. The Act

Section 16:

> (1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation. ….

POLICY

Formal Training

Subject to the policy C11-88.00, "Nature and Extent of Programs and Services", 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 who is assessed under section 23(3) in mitigating his or her 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 16(1) 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 award 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 16(1) 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 16(1) 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 16(1) 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 16(1). If the worker wished to meet the cost of the program by a commutation of a permanent disability award, 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 16(1) of the *Act* will normally include:

1. Training allowances at wage-loss equivalency when 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 16(1) 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~~s~~ and will be subject to cost-of-living adjustments using the formula provided in section 25 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 benefits 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 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 39(1)(e).

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.

PRACTICE

For practice information, see any relevant Practice Directives available on the WorkSafeBC website:

EFFECTIVE DATE:	September 1, 2015
AUTHORITY:	Section 16 of the *Act*.
CROSS REFERENCES:	Item C3-20.00, *Employer-Provided Facilities*; Item C3-22.00, *Compensable Consequences*; Policy item #45.44, *Education*; 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*; Policy item #114.40, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*; and

	Policy item #115.30, *Experience Rating* of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	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. Replaces policy items #88.50 - #88.55 of the *Rehabilitation Services & Claims Manual,* Volume II. Applies to decisions made on or after November 1, 2002 on claims adjudicated under the *Act*, 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 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 16:

> (1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it 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. 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.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	November 1, 2002
AUTHORITY:	Section 16 of the *Act*.
CROSS REFERENCES:	Starting a Business (policy item #45.43), and Vocational Rehabilitation - Nature and Extent of Programs and Services (Item C11-88.00) of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	Replaces 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 *Act*, as amended by the *Workers Compensation Amendment Act, 2002*.

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 16:

(1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it 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 16 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 industrial 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 suffer 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.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	June 1, 2009 – Delete reference to officer.
AUTHORITY:	Section 16 of the *Act*.
CROSS REFERENCES:	
HISTORY:	November 1, 2002 - Reformatted and revised policy to set out the legal assistance that may be provided in relation to vocational rehabilitation. Replaces policy item #88.70 of the *Rehabilitation Services & Claims Manual,* Volume II. Applies to decisions made on or after November 1, 2002 on claims adjudicated under the *Act*, 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 16:

> (1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it 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 old 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.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	November 1, 2002
AUTHORITY:	Section 16 of the *Act*.
CROSS REFERENCES:	Vocational Rehabilitation - Process (Item C11-87.00) of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	Replaces 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 *Act*, as amended by the *Workers Compensation Amendment Act, 2002*.

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 16:

(1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation. ….

Section 30:

(1) … if a temporary partial disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment 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 23:

(3) … if

(a) a permanent partial disability results from the a worker's injury, and

(b) the Board makes a determination under subsection (3.1) with respect to the worker,

the Board may pay the worker compensation that is a periodic payment that equals 90% of the difference between

(c) the average net earnings of the worker before the injury, and

(d) 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.

(3.1) A payment may be made under subsection (3) only if the Board determines that the combined effect of the worker's occupation at the time of the injury and the worker's disability resulting from the injury is so exceptional that an amount determined under subsection (1) does not appropriately compensate the worker for the injury.

(3.2) In making a determination under subsection (3.1), the Board must consider the ability of the worker to continue in the worker's occupation at the time of the injury or to adapt to another suitable occupation.

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 wage loss.

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. There must be objective evidence 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.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	November 1, 2002
AUTHORITY:	Section 16 of the *Act*.
CROSS REFERENCES:	Sections 30 and 23(3) of the *Act,* Availability of Jobs *(*policy item #35.21), Suitable Occupation (policy item #40.12), and Vocational Rehabilitation - Employability Assessments – Temporary Partial Disability and Permanent Partial Disability (Item C11-89.00) of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	Replaces, in part, policy item #40.12.
APPLICATION:	To decisions made on or after November 1, 2002 on claims adjudicated under the *Act*, as amended by the *Workers Compensation Amendment Act, 2002.*

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 16:

(1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation. ….

Section 30:

(1) … if a temporary partial disability results from a worker's injury, the Board must pay the worker compensation that is a periodic payment 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 23:

(3) … if

(a) a permanent partial disability results from the a worker's injury, and

(b) the Board makes a determination under subsection (3.1) with respect to the worker,

the Board may pay the worker compensation that is a periodic payment that equals 90% of the difference between

(c) the average net earnings of the worker before the injury, and

(d) 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)

(3.1) A payment may be made under subsection (3) only if the Board determines that the combined effect of the worker's occupation at the time of the injury and the worker's disability resulting from the injury is so exceptional that an amount determined under subsection (1) does not appropriately compensate the worker for the injury.

(3.2) In making a determination under subsection (3.1), the Board must consider the ability of the worker to continue in the worker's occupation at the time of the injury or to adapt to another suitable occupation. ….

POLICY

Employability Assessments

Sections 30 and 23(3) of the *Act* enable the Board to estimate what a worker is capable of earning in a suitable occupation. This requires 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 30(1) and 23(3) 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 payments may be processed under section 30 of the *Act*. In most cases, the Board conducts the assessment under section 30. 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.

A referral to Vocational Rehabilitation Services may be made if assistance is needed in this regard or a more comprehensive employability assessment is required. For example, if there is no attachment to the pre-injury employer, suitable and available occupations in the labour market will be considered.

Documented objective evidence of what the worker is earning or is capable of earning is provided to the Board, who makes the decision on a worker's entitlement under section 30.

In determining section 30 benefits, the employment opportunity or opportunities should be available immediately or within the period under review (two weeks, one month) and there should be some certainty that workers would have these opportunities open to them 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 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

In exceptional cases, a worker's entitlement to a permanent partial disability award may be assessed under the method set out in section 23(3) of the *Act*. This method requires 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.

The worker is given a copy of the assessment and 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 final decision on section 23(3) entitlement.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officer, Compensation Services and Vocational Rehabilitation Services.
AUTHORITY:	Sections 16, 23 and 30 of the *Act*.
CROSS REFERENCES:	Procedure for Determining Whether Worker is Temporarily Partially Disabled (policy item #35.11), Amount of Payment (policy item #35.20), Suitable Occupation (policy item #35.21), Section 23(3) Assessment Formula (policy item #40.10), Suitable Occupation (policy item #40.12), Measurement of Earnings Loss (policy item #40.13), Provision of Employability Assessments (policy item #40.14), and Vocational Rehabilitation - Income Continuity (Item C11-89.10), of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	November 1, 2002 - Reformatted and revised policy to set out the employability assessment process for temporary partial disability and permanent partial disability. Replaces policy items #89.00, #89.10, and #89.20 of the *Rehabilitation Services & Claims Manual,* Volume II. Applies to decisions made on or after November 1, 2002 on claims adjudicated under the *Act*, as amended by the *Workers Compensation Amendment Act, 2002.*
APPLICATION:	Applies on or after June 1, 2009

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 a permanent disability award under section 23(3).

2. The Act

Section 16:

(1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the Board may take the measures and make the expenditures from the accident fund that it considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation. ….

Section 23:

(3) … if

(a) a permanent partial disability results from the a worker's injury, and

(b) the Board makes a determination under subsection (3.1) with respect to the worker,

the Board may pay the worker compensation that is a periodic payment that equals 90% of the difference between

(c) the average net earnings of the worker before the injury, and

(d) 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)

(3.1) A payment may be made under subsection (3) only if the Board determines that the combined effect of the worker's occupation at the time of the injury and the worker's disability resulting from the injury is so exceptional that an amount determined under subsection (1) does not appropriately compensate the worker for the injury.

(3.2) In making a determination under subsection (3.1), the Board must consider the ability of the worker to continue in the worker's occupation at the time of the injury or to adapt to another suitable occupation.

POLICY

Continuity of Income Pending Assessment of Permanent Disability Award

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 disability pension. This allowance 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 temporary wage-loss benefits,
- who are not receiving other wage-loss equivalency benefits from the Board, and
- who are likely to receive a permanent partial disability award under section 23(3) of the *Act*

Consideration will be given to the payment of a rehabilitation allowance between the end of wage-loss or other wage replacement payments and the commencement of the permanent disability award under section 23(3).

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 disability award is granted, 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 will complete the employability assessment required under section 23(3), and will provide a copy of that assessment to the worker. Thirty (30) 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 Award Reopenings

Continuity of income payments will also be considered for workers who are already receiving a permanent disability award on the claim, where the Board has reopened the award decision and it is likely that the worker will receive a significant increase in the award. 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.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officers and Board officers in Vocational Rehabilitation Services.
AUTHORITY:	ss.16 and 23(3) of the *Act*.
CROSS REFERENCES:	Suitable Occupation (policy item #40.12), and Vocational Rehabilitation - Employability Assessments – Temporary Partial Disability and Permanent Partial Disability (Item C11-89.00) of the *Rehabilitation Services & Claims Manual,* Volume II.
HISTORY:	March 3, 2003 - Amendments to reference a reopening of a permanent disability award, consequential to the *Workers Compensation Amendment Act (No. 2), 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 section 23(3) of the *Act*. Replaces policy items #89.11 and #89.13 of the *Rehabilitation Services & Claims Manual,* Volume II. Applies to decisions made on or after November 1, 2002 on claims adjudicated under the *Act*, as amended by the *Workers Compensation Amendment Act, 2002.*
APPLICATION:	Applies on or after June 1, 2009

RE: Vocational Rehabilitation
Vocational Assistance for Surviving 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 surviving spouses and dependants of deceased workers.

2. The Act

Section 16:

(2) Where compensation is payable under this Part as the result of the death of a worker, the Board may make provisions and expenditures for the training or retraining of a surviving dependent spouse, regardless of the date of death.

(3) The Board may, where it considers it advisable, provide counselling and placement services to dependants.

POLICY

Vocational Assistance for Surviving Spouses and Dependants of Deceased Workers

Where a worker's death is compensable, the Board has statutory authority to provide counselling and placement services to the surviving spouse and 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 Surviving 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. Spouses who receive periodic pension awards are eligible for training assistance.

2. Sponsorship of training will be considered for spouses who were not employed at the time of the worker's death, or were employed in occupations with limited financial prospects. 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 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 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 spouse's former occupation, and the financial impact of the worker's death on the household. If the spouse has job-ready skills in an occupation that has reasonable prospects, training assistance will not normally be provided.

4. The 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 16(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 spouse meets the entry requirements for the training program and has a reasonable prospect of completing the program successfully.

2. Assistance under section 16(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 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 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 16(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 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 16(2) may result from an application by the surviving spouse, or it may result from an initiative and proposal by the Board, or others concerned with the claim, with which the surviving 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 16(2) of the *Act* will normally include payment of:

1. Tuition fees and necessary books, materials or equipment.

2. Travel and subsistence expenses and homemaker allowances, including child care, where appropriate.

3. An additional living allowance may be paid as follows:

   (a) The 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 Board pension, Canada Pension Plan benefits, allowances from Human Resources and Skills Development Canada, 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 training allowance sufficient to raise the

spouse's income to the minimum. The allowance is payable to the spouse during the period required to complete the training program.

(c) The minimum is equal to the weekly equivalent of 60% of 90% of the minimum average earnings prescribed by section 17(3)(c) for calculating pensions payable to spouses of deceased workers. This formula is essentially the same as is set out in section 17(3)(c) for calculating the total pension (including Canada Pension benefits) payable to an invalid spouse or spouse over 50 without children.

(d) Whether or not a spouse's income falls below the minimum, the Board may supplement the income of the spouse when the actual expenses incurred during the course of the program exceed what is covered by the above items.

Vocational Services to Dependants of Deceased Workers

As long as no expenditures are involved, section 16(3) permits the Board to provide counselling and placement services to other dependants of decease workers when the Board considers it advisable to make these services available.

PRACTICE

For any relevant PRACTICE information, please consult the WorkSafeBC website at worksafebc.com.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officers in Vocational Rehabilitation Services and update reference to Human Resources and Skills Development Canada.
AUTHORITY:	Section 16.
CROSS REFERENCES:	Item C8-56.00, *Compensation on the Death of a Worker – Calculation of Compensation – Surviving Spouse with Children*; Item C8-56.10, *Compensation on the Death of a Worker – Calculation of Compensation – Surviving Spouse with No Children*; Item C10-83.00, *Transportation*; Item C10-83.10, *Subsistence Allowances*.

HISTORY: December 31, 2003 – Consequential changes were made to this Item as a result of legislative changes to the manner in which survivor benefits are calculated under section 17 of the *Act*. Those legislative changes were retroactive to June 30, 2002. November 1, 2002 – Reformated and Revised policy. Replaces places policy items #91.00 and #91.20 of the *Rehabilitation Services & Claims Manual,* Volume II. Applies to decisions made on or after November 1, 2002 on claims adjudicated under the *Act*, as amended by the *Workers Compensation Amendment Act, 2002.*

APPLICATION: Applies on or after June 1, 2009

CHAPTER 12

CLAIMS PROCEDURES

#92.00 INTRODUCTION

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

#93.00 RESPONSIBILITIES OF CLAIMANTS

#93.10 Report to Employer

Section 53(1) provides that "In every case of an injury or disabling occupational disease to a worker in an industry within the scope of this Part, the worker, or in case of death the dependant, must as soon as practicable after the occurrence inform the employer by giving information of the disease or injury to the superintendent, first aid attendant, supervisor, agent in charge of the work where the injury occurred or other appropriate representative of the employer, and the information must include the name of the worker, the time and place of the occurrence, and, in ordinary language, the nature and cause of the disease or injury."

Where the worker's condition results from a series of injuries rather than just one injury, section 53(1) is complied with if the report to the employer is made as soon as practicable after the last injury in the series.

In the case of an occupational disease, the employer to be informed of the death or disablement is the employer who last employed the worker in the employment to the nature of which the disease was due. (1)

Where the injury or disease is suffered by a commercial fisher, the "employer" to whom the fisher must report is set out in section 10 of the *Fishing Industry Regulations*.

EFFECTIVE DATE: March 18, 2003 (as to the deletion of reference to the *Workers' Compensation Reporter* Decision No. 223)

APPLICATION: Not applicable.

#93.11 Procedure for Reporting

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

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

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

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

Many employers set up their own system of reporting to assist them in carrying out their obligations. If the worker, however, reports to some other company official who was not designated by the employer, this does not mean there is no compliance with his or her responsibilities under the *Act*.

#93.12 Failure to Report

Section 53(4) 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 disease or injury suffered, and the occasion of it;

(b) the employer or the employer's representative had knowledge of it; 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 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 53(1).

#93.20 Application for Compensation

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

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

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

#93.21 Time Allowed for Submission of Application

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

Section 55 is applied to claims for compensation for mental disorders under section 5.1 as it is applied to claims for compensation for injuries under section 5.

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

The section is not complied with simply by reporting the injury to the first aid attendant or having it confirmed by witnesses. The one-year period commences at the date of injury or death, and except in the case of occupational diseases, not at the date of subsequent disablement. In the case of occupational diseases, reference should be made to policy item #32.50.

EFFECTIVE DATE:	December 1, 2013
CROSS REFERENCES:	Policy item #93.22, Application Made Out of Time.
HISTORY:	December 1, 2013 – Policy amended to clarify that Section 55 of the *Act* applies to claims for compensation of mental disorders under section 5.1, in the same manner as it is applied to compensation for injuries under section 5.
APPLICATION:	Applies to all decisions, including appellate decisions made on or after December 1, 2013.

#93.22 Application Made Out of Time

Before an application for compensation can be considered on its merits, it must satisfy the requirements of section 55. It is important to distinguish between the decision on the merits of the claim and the decision made under section 55, since the distinction may affect the rights of appeal which a person has to challenge the decision. A separate decision on the effect of Section 55 must always be reached on a claim.

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

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

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

(a) the Board is satisfied that special circumstances existed which precluded the filing of an application within one year after the date referred to in subsection (2), and

(b) the application is filed more than 3 years after the date referred to in subsection (2).

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

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

(b) sufficient medical or scientific evidence was not available on the date referred to in subsection (2) for the Board to recognize the disease as an occupational disease and this evidence became available on a later date, and

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

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

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

1. There must have existed special circumstances which precluded the application from being filed within that period, and

2. The Board must exercise its discretion to pay compensation.

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

1. Special Circumstances

It is not possible to define in advance all the possible situations that might be recognized as special circumstances which precluded the filing of an application. The particular circumstances of each case must be considered and a *judgment made. However, it should be made clear that in* determining whether special circumstances existed, the concern is solely with the 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 suffer a genuine work injury.

The following facts illustrate a situation where special circumstances were found to exist. The worker suffered a minor right wrist injury on October 20, 1976, which at the time caused him no disablement from work and did not require him to seek medical attention. There was, therefore, no reason why he should claim compensation from the Board, nor any reason why his doctor or employer should submit reports to the Board. It was not until 1978 when the worker began to experience problems with his right wrist

that he submitted a claim to the Board. It was only then that he was incurring monetary losses for which compensation might be appropriate.

2. Discretion of the Board

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

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

The exercise of the Board's discretion depends on the extent to which the lapse of time since the injury has prejudiced the Board's ability to carry out the necessary investigations into the validity of the claim. The length of time elapsed will be a significant factor here, together with the nature of the injury. Also significant will be whether there are witnesses or other persons to whom the worker reported the injury and from whom he sought treatment for it who are still able to provide accurate statements to the Board. The Board will not exercise its discretion under section 55(3) in favour of allowing an application to be considered where, because of the time elapsed, sufficient evidence to determine the occurrence of the injury and its relationship to the 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 his 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 55(3) may, in some cases, appear in substance to be closely related to the question that would arise on the merits of the claim as to whether the injury in question occurred and whether it caused the 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 item #93.22 it is always necessary, in any event, to separate the decision on the merits and the exercise of discretion under section 55(3).

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

EFFECTIVE DATE: June 1, 2009 – Delete reference to Board officer.
HISTORY: March 3, 2003 – Insert new wording of section 55(3.3)
APPLICATION: Applies on or after June 1, 2009

#93.23 Adjudication without an Application

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

In accordance with this provision, 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. A disability award may result.
4. In personal optional protection cases before wage loss is payable.
5. Where a preliminary determination under policy item #96.21 is carried out.
6. In third-party and out-of-province cases.
7. Silicosis claims.

8. On fatal claims before a pension can be paid. A decision on the acceptability of the claim and the payment of funeral and lump-sum benefits can be made without an application.

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

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

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officer.
HISTORY:	March 3, 2003 – Amended to reference preliminary determinations under policy item #96.21.
APPLICATION:	Applies on or after June 1, 2009

#93.25 Signature on an Application for Compensation

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

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

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

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

#93.26 Obligation to Provide Information

Section 57.1 of the *Act* provides as follows:

(1) A worker who applies for or is receiving compensation 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.

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.

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., Human Resources and Skills Development Canada or 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 his or her 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: June 1, 2009 – Update reference to Human Resources and Skills Development Canada and Canada Revenue Agency.

APPLICATION: Applies on or after June 1, 2009

#93.30 Medical Treatment and Examination

The obligations of an injured worker to undertake medical treatment and examination are discussed in Item C10-73.00, *Direction, Supervision, and Control of Health Care*.

#93.40 Working While Receiving Wage-Loss Benefits

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

#94.00 RESPONSIBILITIES OF EMPLOYERS

#94.10 Report to the Board

Subject to policy items #94.12 and #94.13, an employer shall report to the Board within three days of its occurrence every injury to a worker that is or is claimed to be one arising out of and in the course of employment.

Subject to policy items #94.12 and #94.13, an employer shall report to the Board within three days of receiving information under section 53, (8) every disabling occupational disease, or claim for or allegation of an occupational disease.

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

The application of the above provisions to claims by commercial fishers is discussed in sections 4 and 10 of the *Fishing Industry Regulations*.

EFFECTIVE DATE: March 18, 2003 (as to the deletion of references to the *Workers' Compensation Reporter* Decision Nos. 223 and 224)

APPLICATION: Not applicable.

#94.11 Form of Report

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

1. the name and address of the worker;
2. the time and place of the disease, injury, or death;
3. the nature of the injury or alleged injury;
4. the name and address of any physician or qualified practitioner who attended the worker; and
5. any other particulars required by the Board or by the regulations, and may be made by mailing copies of the form addressed to the Board at the address the Board prescribes.

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

Form 7	Employer's Report of Injury or Occupational disease
Form 9	Employer's Subsequent Statement (Completed at the employer's option or at the Board's request, as soon as the injured worker has returned, or is able to work.)

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

#94.12 What Injuries Must Be Reported

A reportable injury is an injury arising out of and in the course of employment, 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.

1. The worker loses consciousness following the injury, or

2. 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, or

3. The injury is one that obviously requires medical treatment, or

4. The worker states an intention to seek medical treatment, or

5. The worker has received medical treatment for the injury, or

6. The worker is unable or claims to be unable by reason of the injury to return to his or her usual job function on any working day subsequent to the day of injury, or

7. The injury or accident resulted or is claimed to have resulted in the breakage of an artificial member, eyeglasses, dentures, or a hearing aid, or

8. The worker or the Board has requested that an employer's report be sent to the Board.

Section 54(6) provides that ". . . the board may by regulation

> (a) define and prescribe a category of minor injuries not required to be reported under this section; . . ."

Where none of the conditions listed 1 to 8 above are present, an injury is a minor injury and not required to be reported to the Board unless one of those conditions subsequently occurs.

#94.13 Commencement of the Obligation to Report

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

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

#94.14 Adjudication and Payment without Employer's Report

An employer is always given an adequate opportunity to submit a Form 7 employer's report before a claim is adjudicated in its absence. If a claim is adjudicated without a Form 7 employer's report and then, after adjudication to allow and pay the claim, the employer's report is received objecting to the acceptability of the claim, the 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 and within 75 days of when the decision on the claim was made, the Board is satisfied that on the basis of new evidence, a mistake of evidence, a policy error or a clear error of law that the claim should not have been accepted, the Board may reconsider the decision.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officer.
HISTORY:	March 3, 2003 – Insert references to review, appeal and reconsideration
APPLICATION:	Applies on or after June 1, 2009

#94.15 Penalties for Failure to Report

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

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

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

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

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

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

Prior to charging the cost of any particular claim to an employer under section 54(8), the 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 Form 7's arrival, they number fewer than ten.

2. A report is requested by the Board to start a new claim after investigation of a reopening indicates a new incident. However, the Form 7 must be received within three days from the date the firm is notified of the new claim.

3. The 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, rehabilitation, and wage-loss payments relating to the period in question, even though they are not actually paid until some time afterwards.

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

The term “interim adjudication” used in this context should not be confused with the 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 item #96.21. The requirements of the preliminary determination procedure do not have to be met for an interim adjudication under section 54(7). It is sufficient if the claim does appear to be an acceptable one and is only being held up by the technicality of the employer’s failure to submit a report.

When the Form 7 employer’s report does arrive, it can be considered as evidence in making the final adjudication of the claim. The rules set out in policy item #96.21 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 (12) and to employers with deposit accounts, but not to personal optional protection or Federal Government claims.

Unless the Board receives the Form 7 employer’s report, the interim adjudication becomes the final decision on the acceptability of the claim and is subject to the provisions of section 96(5) of the *Act*.

If the Board receives the Form 7 employer’s report, the final adjudication becomes the final decision on the acceptability of the claim and is subject to the provisions of section 96(5) of the *Act*.

The final adjudication does not constitute a reconsideration of the interim adjudication for purposes of sections 96(4) and (5). Section 54(7) contemplates that a final adjudication will be made, whenever the Form 7 employer’s report is received.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Board officer.
HISTORY:	March 3, 2003 – Insert references to preliminary determination and the status of final adjudication for the purposes of sections 96(4) and (5).
APPLICATION:	Applies on or after June 1, 2009

#94.20 Employer or Supervisor Must Not Attempt to Prevent Reporting

Section 177 of the *Act* provides as follows:

> An employer or supervisor must not, by agreement, threat, promise, inducement, persuasion or any other means, seek to discourage, impede

or dissuade a worker of the employer, or a dependant of the worker, from reporting to the board

(a) an injury or allegation of injury, whether or not the injury occurred or is compensable under Part 1,

(b) an illness, whether or not the illness exists or is an occupational disease compensable under Part 1,

(c) a death, whether or not the death is compensable under Part 1, or

(d) a hazardous condition or allegation of hazardous condition in any work to which this Part applies.

The Board may impose an administrative penalty if it is determined that an employer has violated section 177. The general criteria for calculating administrative penalties are provided in the *Prevention Manual* at Item D12-196-6.

Item D12-196-6 also provides for the recovery of potential or actual benefits obtained from non-compliance.

As an alternative to imposing an administrative penalty, the Board may refer the case to Crown Counsel for consideration of prosecution.

HISTORY: Consequential housekeeping amendments made to reflect changes to the OHS Penalty Amounts policy (Item D12-196-6 in the *Prevention Manual*) that became effective March 1, 2016.

#95.00 RESPONSIBILITIES OF PHYSICIANS/QUALIFIED PRACTITIONERS

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

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

If treatment continues, progress reports must be provided.

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

The duties described in this policy item apply to a psychiatrist or psychologist who diagnoses a worker with a mental disorder under section 5.1(1)(b) of the *Act*.

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

#95.10 Form of Reports

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

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

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

All medical reports must be signed by the person making the report with reference to the professional designation of a partnership or clinic. The original report, not the carbon copy, should be provided to the Board. 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.

#95.20 Reports by Specialist

If the physician is a specialist whose opinion is requested by the attending physician, the worker, or the Board, or if he or she continues to treat the worker after being consulted as a specialist, a first report must be furnished to the Board within three days after completion of the consultation; but if the specialist is regularly treating the worker, the specialist shall submit reports as required in policy item #95.00. (15)

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

#95.30 Failure to Report

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

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

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

#95.31 Payment of Wage-Loss without Medical Reports

Wage-loss compensation is 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 lay-off was a result of the injury, then wage-loss compensation may be paid. Normally, 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.

#95.40 Obligation to Advise and Assist Worker

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

EFFECTIVE DATE: December 31, 2003.

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

#96.00 THE ADJUDICATION OF COMPENSATION CLAIMS

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

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

(b) the existence and degree of disability by reason of an injury;

(c) the permanence of disability by reason of an injury;

(d) the degree of diminution of earning capacity by reason of an injury;

(e) the amount of average earnings of a worker, whether paid in cash or board or lodging or other form of remuneration, . . . for purposes of payment of compensation;

(f) the existence, for the purpose of this Part, of the relationship of a member of the family of a worker as defined by this *Act*;

(g) the existence of dependency;

(h) whether an industry or a part, branch or department of an industry is within the scope of this Part, . . .;

(i) whether a worker in an industry within the scope of this Part is within the scope of this Part and entitled to compensation under it; and

(j) whether a person is a worker, a subcontractor, a contractor or an employer within the meaning of this Part."

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

#96.10 Policy of the Board of Directors

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

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

(a) The statements contained under the heading "Policy" in the *Assessment Manual*;

(b) The *Occupational Safety and Health Division Policy and Procedure Manual*;

(c) The statements contained under the heading "Policy" in the *Prevention Manual;;*

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

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

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

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

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

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

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

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

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

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

APPLICATION: Not applicable.

#96.21 Preliminary Determinations

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 is suffering from 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. (19)

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. Where 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. Where a preliminary determination has been made on a claim and wage loss payments have 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 policy item #113.10.

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 96(5). 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 96(5).

EFFECTIVE DATE: June 1, 2009 – Delete references to Board officer.

HISTORY: March 3, 2003 – Amendments 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

section 96(5). Policy applies to all preliminary determinations made on or after March 3, 2003.

APPLICATION: Applies on or after June 1, 2009

#96.22 Suspension of Claim

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

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

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

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

(1) where the worker leaves the province without notifying the Board or receiving prior consent from the Board; (21)

(2) where the worker is being paid full salary by the Federal Government; (22)

(3) where the worker refuses to accept the cheques;

(4) where a worker moves and the worker's whereabouts are unknown.

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

#96.30 Disability Awards Decision-Making Procedures

The Board determines whether an actual or potential permanent disability is accepted on a claim.

Where the Board has accepted an actual or potential permanent disability, the Board then determines the extent of the disability, and calculates the worker's permanent disability award entitlement.

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

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 a permanent disability award for psychological impairment is discussed in policy item #39.01.

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

The final decision on the assessment of a permanent disability award under section 23(3) is made by the Disability Awards Committee.

Requests for the commutation of permanent disability awards are adjudicated by the Board. Before making a decision, it may be necessary to obtain vocational rehabilitation input.

EFFECTIVE DATE:	June 1, 2009 – Insert reference that a Board officer determines whether an actual or potential disability is accepted on the claim. Delete references to Board officer in Disability Awards, Medical Services and Consultant.
HISTORY:	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 on or after June 1, 2009.

#97.00 EVIDENCE

Under the old English system, which was an adversary system of workers' compensation, there was a burden of proof imposed on the worker, but that is not the correct practice here. The Board must not start with any presumption against the worker, but neither must there be any presumption in the worker's favour. The correct approach is to examine the evidence to see whether it is sufficiently complete and reliable to arrive at a sound conclusion with confidence. If not, the Board should consider what other evidence might be obtained, and must take the initiative in seeking further evidence. After that has been done, if, on weighing the available evidence, there is then a preponderance in favour of one view over the other, that is the conclusion that must be reached. But if it appears upon the weighing of the evidence that the disputed possibilities are evenly balanced then the rule comes into play which requires that the issue be resolved in accordance with that possibility which is favourable to the worker.

Although there is no burden of proof on the 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 there is nothing objective to indicate any activity at work was potentially causative of the condition complained of, at or near the time alleged by the worker, it can fairly be said that the claim 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:	June 1, 2009 – Delete references to officer and Adjudicator.
APPLICATION:	Applies on or after June 1, 2009

#97.10 Evidence Evenly Weighted

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 employment. The essence of the complaint is often that if there is some possibility that the injury arose out of the employment, the worker should be given the benefit of the doubt. For the Board to take that view, however, would be inconsistent with the terms of the *Act*. Where it appears from the evidence that two conclusions are possible, but that one is more likely than the other, the Board must decide the matter in accordance with that possibility that is more likely.

Under the terms of section 99(3), the Board is required to decide an issue in accordance with the possibility which is favourable to the worker where it appears that "the evidence supporting different findings on an issue is evenly weighted in that case". This applies only where there is evidence of roughly equal weight for and against the claim. It does not come into play where the evidence indicates that one possibility is more likely than the other. (23)

While an absence of positive data does not necessarily mean that a condition is not related to a person's employment, it may mean that there is a lack of evidence that any such relationship exists. The Board, as a quasi-judicial body, must make its decisions according to the evidence or lack of evidence received, not in accordance with speculations unsupported by evidence. Section 99(3) of the *Act* applies when "the evidence supporting different findings on an issue is evenly weighted in that case." However, if the Board has no evidence before it that a particular condition can result from a worker's employment, there is no doubt on the issue; the Board's only possible decision is to deny the claim. If one speculates as to the cause of a condition of unknown origin, one might attribute it to the person's work or to any other cause, and one speculated cause is no doubt just as tenable as any other. However, the Board can only be concerned with possibilities for which there is evidential support and only when the evidence is evenly weighted does section 99(3) apply.

EFFECTIVE DATE: March 3, 2003 (as to new wording of section 99)
APPLICATION: Not applicable.

#97.20 Presumptions

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

(1) In cases where the injury is caused by accident, where the accident arose out of the employment, unless the contrary is shown, it shall

be presumed that it occurred in the course of the employment; and where the accident occurred in the course of the employment, unless the contrary is shown, it shall be presumed that it arose out of the employment. (24)

(2) If the worker at or immediately before the date of disablement was employed in a process or industry mentioned in the second column of Schedule B, and the disease contracted is the disease in the first column of the schedule set opposite to the description of the process, the disease shall be deemed to have been due to the nature of that employment unless the contrary is proved. (25)

(3) Where a deceased worker was, at the date of death, under the age of 70 years and suffering from an occupational disease of a type that impairs the capacity or function of the lungs, and where the death was caused by some ailment or impairment of the lungs or heart of non-traumatic origin, it shall be conclusively presumed that the death resulted from the occupational disease. (26)

(4)(a) Where a worker who is or has been a firefighter has contracted a disease set out in the *Act* or prescribed by the *Firefighters' Occupational Disease Regulation*, the disease must be presumed to be due to the nature of the worker's employment as a firefighter, unless the contrary is proved. (26a)

(4)(b) Where a worker is disabled as a result of a heart disease and was employed as a firefighter at 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. (26b)

(4)(c) Where a worker is disabled as a result of a heart injury and was employed as a firefighter at 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. (26c)

(5) Where a worker who is an applicant as defined in the *Emergency Intervention Disclosure Act*, has obtained a testing order under that Act, and has contracted a communicable disease prescribed by the *Emergency Intervention Disclosure Regulation*, it must be presumed the communicable disease is due to the nature of the worker's employment, unless there is evidence to the contrary. (26d)

(6) Where a worker is or has been employed in an eligible occupation and 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 is diagnosed by a psychiatrist or psychologist as a mental disorder recognized in the most recent American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders at the time of the diagnosis 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. (26e)

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

EFFECTIVE DATE:	July 23, 2018
HISTORY:	Consequential amendments arising from the Bill 9 amendments to section 5.1 of the *Act*, were made effective July 23, 2018. May 1, 2017 – Adding to policy a reference to the firefighters' presumption and communicable disease presumption provided in the *Act.*
APPLICATION:	Applies on or after July 23, 2018.

#97.30 Medical Evidence

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 guide-rules are set out below.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Claims Adjudicator, Claims Officer, the Disability Awards Officer and the Adjudicator in Disability Awards.
APPLICATION:	Applies on or after June 1, 2009.

#97.31 Matter Requiring Medical Expertise

Where the matter is one requiring medical expertise, the decision must be preceded by a consideration of medical evidence (this term includes medical opinion or advice). Medical evidence might consist of a statement in the Form 8 Physician's First Report, (27) 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.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Claims Adjudicator and Claims Officer.
APPLICATION:	Applies on or after June 1, 2009.

#97.32 Statement of Worker about His or Her Own Condition

A statement of a worker about his or her 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 his or her 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 his or her 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 his or her knowledge.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Claims Adjudicator, Claims Officer and Board Medical Advisor.
APPLICATION:	Applies on or after June 1, 2009.

#97.33 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 fellow worker that he or she saw the worker suffering from silicosis would be worthless; but a statement by a fellow worker reporting to have seen the worker bleeding from the forehead would be evidence of a head wound. 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.

#97.34 Conflict of Medical Opinion

Where 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 her or his own conclusions about where the preponderance of the evidence lies. If it is concluded that there is doubt on any issue, and that the evidence supporting different findings on an issue is evenly weighted in that case, the Board must follow the mandate of section 99 and resolve that issue in a manner that favours the worker. (28)

It should never be assumed that there is a conflict of medical opinion simply because the opinions of different doctors indicate different conclusions. A difference in conclusion between doctors may or may not result from a difference in medical opinion. For example, the difference could result from different assumptions of non-medical fact. Where there are two or more medical reports or memos on file from physicians, indicating different conclusions, the 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.

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

The Board has no rule 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. (29)

EFFECTIVE DATE:	June 1, 2009 – Delete references to officers.
HISTORY:	March 3, 2003 – Insert new wording of section 99.
APPLICATION:	Applies on or after June 1, 2009.

#97.35 Termination of Benefits

Where 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:	June 1, 2009 – Delete references to Claims Adjudicator, Claims Officer and Board physician.
APPLICATION:	Applies on or after June 1, 2009.

#97.40 Disability Awards

In cases of very minor disabilities, the Board may proceed to calculate a disability award without a section 23(1) evaluation, if it is unnecessary having regard to the medical evidence already available. Except for those cases, the normal practice is for a section 23(1) evaluation to be conducted for disability awards 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 23(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 23(1) evaluation report takes the form of expert evidence which, in the absence of other expert evidence to the contrary, should not be disregarded. This does not mean that the Board must adopt the percentage indicated by the section 23(1) evaluation. It is always open to the Board to conclude that, although the functional impairment of the worker is a certain percentage, the disability (i.e. the extent to which that impairment affects the worker's ability to earn a living) is greater or less than the percentage of impairment.

The decision-making procedure for assessing entitlement to a permanent disability award for psychological impairment under section 23(1) of the *Act* is discussed in policy item #39.01.

In making a determination under section 23(1), the Board will enquire carefully into all of the circumstances of a worker's condition resulting from a compensable injury.

EFFECTIVE DATE:	June 1, 2009 – Delete references to officers in Disability Awards and officer.
HISTORY:	January 1, 2003 – References to prior Subjective Complaints policy removed. Applies to new claims received and all active claims that are currently awaiting an initial adjudication.
APPLICATION:	Applies on or after June 1, 2009.

#97.50 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.

#97.60 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.

#98.00 INVESTIGATION OF CLAIMS

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.

#98.10 Powers of the Board

Section 87 of the *Act* provides as follows:

(1) The Board has the like powers as the Supreme Court to compel the attendance of witnesses and examine them under oath, and to compel the production and inspection of books, papers, documents and things.

(2) The Board may cause depositions of witnesses residing in or out of the Province to be taken before a person appointed by the Board in a similar manner to that prescribed by the Rules of the Supreme Court for the taking of like depositions in that court before a commissioner.

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

EFFECTIVE DATE: March 3, 2003 (as to new wording of section 87)
APPLICATION: Not applicable.

#98.11 Powers of Officers of the Board

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

The officer and every other person appointed to make an inquiry has for the purposes of an inquiry under subsection (1) all the powers conferred upon the Board by section 87. (30)

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

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

EFFECTIVE DATE: March 3, 2003 (as to new wording of section 88)
APPLICATION: Not applicable.

#98.12 Examination of Books and Accounts of Employer

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

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

#98.13 Medical Examinations and Opinions

The authority of the Board to require a worker to be medically examined is dealt with in Item C10-73.00, *Direction, Supervision, and Control of Health Care*.

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.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Medical Advisors and officers.
HISTORY:	Consequential amendments arising from changes to Chapter 10, *Medical Assistance, Rehabilitation Services and Claims Manual*, were made effective January 1, 2015. March 3, 2003 – Deletion of references to Review Division and Appeal Division.
APPLICATION:	Applies on or after June 1, 2009.

#98.20 Conduct of Inquiries

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

#98.21 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.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Adjudicators and Claims Adjudicators.
APPLICATION:	Applies on or after June 1, 2009.

#98.22 Failure of Worker to Appear

If the worker fails or refuses to appear at an inquiry, her or his claim may be suspended, or decided in her or his absence, or a further appointment may be arranged.

#98.23 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.

#98.24 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 he or she 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.

#98.25 Oaths

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

If:

1. a person called to give evidence objects to taking an oath, or is objected to as incompetent to take an oath, and the Board is satisfied of the sincerity of the objection of the witness from conscientious motives to be sworn or that the taking of an oath would have no binding effect on his or her conscience;

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

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

#98.26 Witnesses and Other Evidence

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

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

#98.27 Cross-examination

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

Cross-examination may, however, sometimes be permitted.

#99.00 DISCLOSURE OF INFORMATION

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

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

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

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

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

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

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

Dispute Resolution

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

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

EFFECTIVE DATE:	June 1, 2009 – Delete references to Manager and Service Delivery Locations.
HISTORY:	March 3, 2003 – Reference to the provision of copies of records related to a matter under review or appeal.
APPLICATION:	Applies on or after June 1, 2009.

#99.10 Disclosure of Issues Prior to Adjudication

Where 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.

Where 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 – Delete references to Adjudicator.
HISTORY:	January 1, 2005 – Housekeeping amendment to require written authorization for disclosure.
APPLICATION:	Applies on or after June 1, 2009.

#99.20 Notification of Decisions

1. Definitions

A “decision” is a determination of the Board to award, deny, reconsider or limit entitlement to benefits and services, or impose or relieve an obligation, pertaining to compensation or rehabilitation matters under Part 1 of the *Act* or policy.

An “affected person” is a worker, employer or a deceased worker’s dependant, 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.

2. 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 are responsible for 20% of the exposure or more, decision letters and review and/or appeal information are sent to the employers' association that best represents the appropriate sector and rate group of that industry.

A. 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 temporary disability benefits, a permanent disability award, benefits for a fatality 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; and
- Decisions on whether an employer may be granted a relief of costs.

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 healthcare providers, such as physicians and pharmacists.

Where 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.

B. 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 award 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, where 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.

3. 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 75-day time limit 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.

4. Rejected Claims

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

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

If a claim is rejected, notification of the review and/or appeal procedures is provided to the person making the claim.

EFFECTIVE DATE:	April 1, 2010
HISTORY:	June 1, 2009 – Delete reference to send a cheque and replace 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 – Insert references to evenly weighted evidence and the rights of review and/or appeal.
APPLICATION:	Applies to all decisions made on or after April 1, 2010.

#99.22 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 they make on claims. Generally, the party in question will be either asking for further

explanation of the decision or expressing dissatisfaction with the substance of the decision.

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

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

EFFECTIVE DATE:	June 1, 2009 – Delete references to officers and manager in the Compensation Services Division.
HISTORY:	January 1, 2005 – Housekeeping amendment to require written authorization for disclosure of information. March 3, 2003 – Insert reference to C14-103.01 and delete references to Review Board.
APPLICATION:	Applies on or after June 1, 2009.

#99.23 Unsolicited Information

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

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

1. Unsolicited information that is clearly irrelevant to the administration of the worker's claim will be destroyed.

2. Unsolicited information that appears to be relevant or potentially relevant to the administration of the worker's claim will be investigated for accuracy.

3. Where, after investigation, the information is determined to be inaccurate or its accuracy is unknown, the information will be destroyed, including any record that initiated the investigation, the investigation report and any documentation obtained in connection with the investigation.

4. Where, after investigation, the information is determined to be accurate, a final assessment as to relevancy will be made.

5. Where accurate information is considered to be irrelevant to the administration of the worker's claim, the information will be destroyed, including any record that initiated the investigation, the investigation report and any documentation obtained in connection with the investigation.

6. Where accurate information is considered to be relevant or potentially relevant to the administration of the worker's claim, the information is placed on the worker's claim as follows:

   (a) anonymous information — The investigation report and any documentation obtained in connection with the investigation will be placed on the claim. The record that initiated the investigation will be destroyed and the claim will state that the investigation was initiated on the basis of information received.

   (b) information from identified source — The record that initiated the investigation, the investigation report and any documentation obtained in connection with the investigation will be placed on the claim.

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

7. If only some of the information is accurate and only some of the accurate information is relevant or potentially relevant to the administration of the worker's claim, the record that initiated the investigation will be destroyed and reference will only be made on the worker's claim to information that is both accurate and relevant or potentially relevant.

8. If, during the investigation, accurate information is discovered that is unrelated to the subject matter of the unsolicited information, butis relevant to the administration of the worker's claim, that information will be recorded separately on the worker's claim.

9. Where unsolicited information is found to be accurate and relevant or potentially relevant to the administration of the worker's claim, the worker will be advised of the information and given an opportunity to comment. Complaints about the accuracy and relevancy of unsolicited information will be dealt with according to policy item #99.35 - Complaints Regarding File Contents.

#99.24 Notification of Permanent Disability Awards

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

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

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

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

#99.30 Disclosure of Claim Files

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

In recognition of the sensitive nature of sexual assault claims where the employer is alleged to be the perpetrator of the assault, all such cases, regardless of the residence of the worker, are assigned to the Sensitive Claims Area. Disclosure

of these claim files for review or appeal and other legal purposes is administered by the Sensitive Claims Area.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Adjudicator, Board officers, physicians, Board Medical Advisers, Manager and Board staff.
HISTORY:	March 3, 2003 – Insert reference to review.
APPLICATION:	Applies on or after June 1, 2009.

#99.31 Eligibility for Disclosure

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

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

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

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

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

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

#99.32 Provision of Copies of File Documents

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

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

Only one copy of each claim file is provided. The person entitled to disclosure must decide whether the copy is to go to them or to an authorized or a

designated advocate or representative or, if there is more than one, which of them should receive the copy.

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

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

#99.33 Personal Inspection of Files

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

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

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

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.

EFFECTIVE DATE: June 1, 2009 – Delete references to Board officers.
APPLICATION: Applies on or after June 1, 2009.

#99.34 Disclosure

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

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

If it is not a review or appeal situation, a worker may obtain disclosure 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.

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

EFFECTIVE DATE:	June 1, 2009 – Delete references to Client Service Managers of the appropriate Service Delivery Location and outside the Richmond area.
HISTORY:	March 3, 2003 – Addition of provision for disclosure after request for review and after appeal filed to WCAT. Deletion of reference to address where requests for disclosure must be submitted by employers and workers. Applies to all decisions made on or after March 3, 2003.
APPLICATION:	Applies on or after June 1, 2009.

#99.35 Complaints Regarding File Contents

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

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

#99.40 Tape Recordings of Interviews

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

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

EFFECTIVE DATE:	June 1, 2009 – Delete reference to officer.
HISTORY:	March 3, 2003 – Insert reference to review.
APPLICATION:	Applies on or after June 1, 2009.

#99.50 Disclosure to Public or Private Agencies

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

(a) Where an appropriate signed consent has been received from the worker.

(b) To any agency having statutory authority allowing access to personal information.

(c) To comply with a subpoena, warrant or order issued or made by a court, person or body with jurisdiction to compel the production of the information.

(d) To a member of the Legislative Assembly who has been requested by the worker to assist in resolving a problem.

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

#99.51 Legal Matters

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

At the request of the Board's General Counsel, a Director or designate will be asked to respond to a subpoena or other request for information from a lawyer.

EFFECTIVE DATE: June 1, 2009 – Delete references to Compensation Services Division, Adjudicator and Board officer.
APPLICATION: Applies on or after June 1, 2009.

#99.52 Other Workers Compensation Boards

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

#99.53 Government of Canada

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

#99.54 Canada Pension Plan

The Board will take all reasonable steps to assist a disabled worker in obtaining benefits to which she or he may be entitled. The 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 resume of the medical findings and the medical assessment of the remaining permanent disability. The Plan is provided with the names of practicing doctors who had been involved in the case. There is no charge for this information.

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

EFFECTIVE DATE:	June 1, 2009 – Delete reference to Medical Services Department and update reference to F.I.P.P. Office.
APPLICATION:	Applies on or after June 1, 2009.

#99.55 Ministry of Housing and Social Development

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

EFFECTIVE DATE:	June 1, 2009 – Update reference to Ministry of Housing and Social Development.
APPLICATION:	Applies on or after June 1, 2009.

#99.56 Police

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

#99.57 Government Employees Compensation Act

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

#99.60 Information to Other Board Departments

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.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Claims Adjudicators and Claims Officers.
APPLICATION:	Applies on or after June 1, 2009.

#99.70 Media Enquiries or Contacts

Unless designated as a media spokesperson, staff at the Board are to refer all media enquiries or contacts to the Communications Department.

EFFECTIVE DATE:	June 1, 2009 – Update reference to the Communications Department.
APPLICATION:	Applies on or after June 1, 2009.

#99.80 Insurance Companies

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

#99.90 Disclosure for Research or Statistical Purposes

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

(a) the research purpose cannot reasonably be accomplished unless that information is provided in individually identifiable form or the research purpose has been approved by the Information and Privacy Commissioner.

(b) any record linkage is not harmful to the individuals that information is about and the benefits to be derived from the record linkage are clearly in the public interest.

(c) the Board has approved conditions relating to the following:

(i) security and confidentiality;

(ii) the removal or destruction of individual identifiers at the earliest reasonable times;

(iii) the prohibition of any subsequent use or disclosure of that information in individually identifiable form without the express authorization of the Board, and

(d) the person to whom that information is disclosed has signed an agreement to comply with the approved conditions, the provisions of the *Freedom of Information and Protection of Privacy Act* and any of the Board's policies and procedures relating to the confidentiality of personal information.

#100.00 REIMBURSEMENT OF EXPENSES

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

The principles relating to expenses incurred in connection with medical examinations and treatment and vocational rehabilitation programs are dealt with in 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. 321/2000) provides that the Board may be ordered by the Workers' Compensation Appeal Tribunal to reimburse a party to an appeal under Part 4 of the *Act* for the following kinds of expenses:

- expenses associated with attending an oral hearing or otherwise participating in a proceeding, if the party is required by the Workers' Compensation Appeal Tribunal to travel to the hearing or other proceeding;

- expenses associated with obtaining or producing evidence submitted to the Workers' Compensation Appeal Tribunal; and

- expenses associated with attending an examination required under section 249(8) of the *Act*.

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

EFFECTIVE DATE:	March 3, 2003 (as to references to the Review Division, the Workers' Compensation Appeal Tribunal and section 7 of the *Workers Compensation Act Appeal Regulation*)
HISTORY:	Consequential amendments arising from changes to Chapter 10, *Medical Assistance, Rehabilitation Services and Claims Manual*, were made effective January 1, 2015.
APPLICATION:	To adjudicative decisions on or after the effective date.

#100.10 Claimants

In addition to the specific requirements set out below, the worker must satisfy the general requirements in Item C10-83.00 and Item C10-83.10 for the payment of transportation and subsistence.

#100.12 Claims or Review Inquiries

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

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

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

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

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

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

#100.13 Medical Review Panels

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

#100.14 Amount of Expenses

The amount of expenses paid is calculated in accordance with the rules set out in Item C10-83.00 (transportation), Item C10-83.10 (meals and accommodation) and Item C10-83.10 (lost time from work where the worker is not already in receipt of temporary disability or vocational rehabilitation benefits from the Board).

#100.15 Worker Resides Outside the Province

The general principle stated in Item C10-83.00 is that, where the Board is paying travel costs of a worker located outside the province, it will only pay the portion attributable to travel in this province. This also applies to claims and review inquiries but there are some exceptions to this principle which apply here.

Where a worker resides outside the province 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.

EFFECTIVE DATE: June 1, 2009 – Delete references to Medical Review Panel.
HISTORY: Consequential amendments arising from changes to Chapter 10, *Medical Assistance, Rehabilitation Services and Claims Manual*, were made effective January 1, 2015.
March 3, 2003 – Insert references to review.
APPLICATION: Applies on or after June 1, 2009.

#100.20 Employers

The expenses of an employer's representative may be reimbursed on the same basis as for a worker, except that compensation benefits for lost time from work are 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.

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

#100.30 Witnesses and Interpreters

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

In other cases, the expenses of an independent witness will be paid where, following the 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. Income-loss benefits 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.

EFFECTIVE DATE:	June 1, 2009 – Delete reference to officer or review officer.
HISTORY:	Consequential amendments arising from changes to Chapter 10, *Medical Assistance, Rehabilitation Services and Claims Manual*, were made effective January 1, 2015. March 3, 2003 – Insert reference to the Review Division.
APPLICATION:	Applies on or after June 1, 2009.

#100.40 Fees and Expenses of Lawyers and Other Advocates

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

#100.50 Expenses Incurred in Producing Evidence

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

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

The Board, in a decision on a claim, refused to pay for medical reports obtained by a worker's lawyer. Although it was a normal and prudent action on the part of a responsible lawyer to seek information in order to acquaint himself properly with his client's problem before pursuing it before the Board, the information contained in the reports could have been obtained from the worker's attending physician at no cost. A simple request to the attending physician, together with a release from the worker, would have been sufficient.

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

EFFECTIVE DATE:	June 1, 2009 – Delete reference to officer.
HISTORY:	March 3, 2003 – Insert references to the Review Division.
APPLICATION:	Applies on or after June 1, 2009.

#100.60 Decision on Expenses

With regard to claims inquiries, any necessary decisions relating to expenses would be 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:	June 1, 2009 – Delete reference to officer.
HISTORY:	March 3, 2003 – Insert references to the Review Division and the Workers' Compensation Appeal Tribunal.
APPLICATION:	Applies on or after June 1, 2009.

#100.70 The Awarding of Costs

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

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

A "contested claim", for the purposes of section 100, is one in respect of which there has been a review by the Review Division by the worker or the employer.

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

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

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

- another party caused costs to be incurred without reasonable cause, or caused costs to be wasted through delay, neglect or some other fault;

- the conduct of another party has been vexatious, frivolous or abusive; or

- there are exceptional circumstances that make it unjust to deprive the successful party of costs.

EFFECTIVE DATE:	June 1, 2009 – Delete reference to Medical Review Panel.
HISTORY:	March 3, 2003 – Insert references to review and section 6 of the *Workers Compensation Act Appeal Regulation.*
APPLICATION:	Applies on or after June 1, 2009.

#100.71 Application for Costs by Dependant

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

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

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

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

#100.72 What Costs May Be Awarded?

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

#100.73 Decisions on Applications for Costs

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

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

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

It may happen that, instead of reaching a specific finding on a matter, the Review Division or the Workers' Compensation Appeal Tribunal will direct that the Board reassess or redetermine something, for example, a permanent partial disability award. The Review Division or the Workers' Compensation Appeal Tribunal finding is properly implemented if the reassessment or redetermination is carried out even if the conclusion reached is the same as the one that was previously reviewed by the Review Division or appealed to the Workers' Compensation Appeal Tribunal. However, if the Board officer implementing the Review Division or the Workers' Compensation Appeal Tribunal finding is the same one who made the original decision against which the review or appeal was made, and if that person's decision is still negative, the matter is to be referred to a different Board officer for a second look. If a difference of opinion results from the second look, the decision of the second Board officer will prevail.

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

Where 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:	June 1, 2009 – Delete references to Compensation Services Division.
HISTORY:	March 3, 2003 – This policy item was moved from Chapter 13 and amended to include references to the Review Division or the Workers' Compensation Appeal Tribunal.
APPLICATION:	Applies on or after June 1, 2009.

#100.80 Payment of Claims Pending Appeals

#100.81 Appeals to the Review Division – New Claims

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

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

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

If the Review Division reverses the decision to allow the claim, payments are immediately terminated but no attempt is made to recover payment incorrectly made to the worker, unless there was evidence of fraud or misrepresentation. The employer's sector or rate group will be relieved of the claim costs pursuant to policy item #113.10.

EFFECTIVE DATE:	June 1, 2009 – Delete reference to Claims Department.
HISTORY:	March 3, 2003 – This policy item was moved from Chapter 13 and amended to include references to the Review Division.
APPLICATION:	Applies on or after June 1, 2009.

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

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

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

EFFECTIVE DATE:	June 1, 2009 – Delete reference to Claims Department.
HISTORY:	March 3, 2003 – This policy item was moved from Chapter 13 and amended to include references to the Workers' Compensation Appeal Tribunal.
APPLICATION:	Applies on or after June 1, 2009.

#100.83 Implementation of Review Division Decisions

Section 258 of the *Act* provides as follows:

(1) If, following a review under section 96.2, a review officer's decision requires payments to be made to a worker or a deceased worker's dependants, the Board must

(a) begin any periodic payments, and

(b) pay any lump sum due under section 17(13).

(2) In the absence of fraud or misrepresentation, an amount paid under subsection (1) to a worker or a deceased worker's dependants is not recoverable.

(3) If a review officer has made a decision described under subsection (1), the Board must defer the payment of any compensation applicable to the time period before that decision

(a) for a period of 40 days following the review officer's decision, and

(b) if the review officer's decision is appealed under section 239, for a further period until the appeal tribunal has made a final decision or the appeal has been withdrawn, as the case may be.

(4) Subsection (3) applies despite sections 19.1, 22(1), 23(1) or (3), 29(1) or 30(1).

(5) If the appeal tribunal's decision on an appeal requires the payment of compensation, all or part of which was deferred under subsection (3), interest must be paid on the deferred amount of that compensation as specified in subsection (6).

(6) Interest payable under subsection (5) must be calculated in accordance with the policies of the board of directors and begins

(a) 41 days after the review officer made his or her decision, or

(b) on an earlier day determined in accordance with the policies of the board of directors.

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

1. Any benefits payable from the date of the Review Division decision forward will be paid without delay.

2. Any benefits payable for the period of time prior to the date of the Review Division decision (retroactive benefits) will be paid after 40 days have elapsed following the date of the Review Division decision unless an appeal has been filed with the Workers' Compensation Appeal Tribunal.

3. If there is an appeal of the decision under section 239 retroactive benefits will not be paid until the Workers' Compensation Appeal Tribunal has made a final decision or the appeal has been withdrawn.

4. The decision of the Workers' Compensation Appeal Tribunal will be implemented upon its receipt by the Board. The worker's entitlement to retroactive benefits which were deferred according to #3 above will then be determined in accordance with the decision of the Workers' Compensation Appeal Tribunal.

5. Where retroactive benefits are payable, after the decision of the Workers' Compensation Appeal Tribunal, interest is to be paid in accordance with the Board's general policy on the payment of interest on retroactive benefits as set out in policy item #50.00. Where interest is payable under section 258(5), interest will be paid beginning 41 days after the date on which the Review Division made its decision. The amount of interest to be paid is to be calculated in accordance with the interest rates set out in policy item #50.00.

EFFECTIVE DATE: January 1, 2014

HISTORY: January 1, 2015 – Housekeeping change to make consequential amendment to bullet 5 of policy resulting from changes to policy item #50.00, *Interest,* of the *Rehabilitation Services & Claims Manual* Volume II made effective January 1, 2014.
June 1, 2009 – Delete reference to officer.
March 3, 2003 – This policy was moved from Chapter 13 and amended to include references to section 258 of the *Act*, the Review Division and the Workers' Compensation Appeal Tribunal and delete a reference to former policy item #45.61.

APPLICATION: This item applies to all decisions made on or after January 1, 2014.

NOTES

(1) S.53(2)

(2) S.53(3)

(3) See policy item #94.11, *Form of Report*

(4) *Workers' Compensation Board of British Columbia, W.C.B. News*, November – December, 1975, 4

(5) S.55(1)

(6) S.55(1)

(7) S.12; See policy item #49.00, *Incapacity of a Worker*

(8) S.54(2)

(9) S.54(3)

(10) S.54(6)(b)

(11) S.54(9)

(12) See policy item #34.40, *Pay Employer Claims*

(13) See Item C10-76.00

(14) S.56(1)(b)

(15) S.56(1)(c)

(16) S.56(5)

(17) S.56(1)(d)

~~(18)~~ ~~S.99~~ **DELETED**

(19) See Chapter 16, *Third Party/Out-of-Province Claims*

(20) See policy item #112.30, *Workers Also Entitled to Compensation in Place of Injury*; policy item #113.30, *Interjurisdictional Agreements*

(21) See Item C10-72.00

(22) See policy item #34.40, *Pay Employer Claims*

(23) *Workers' Compensation Board of British Columbia, W.C.B. News Bulletin*, September – October, 1973

(24) S.5(4); See Item C3-14.20, *Accident – Section 5(4) Presumption*

(25) S.6(3); See policy item #26.21, *Schedule B Presumption*

(26) S.6(11); See policy item #29.50, *Presumption Where Death Results from Ailment or Impairment of Lungs or Heart*

(26a) S.6.1; See policy item #26.22 and Firefighters' Occupational Disease Regulation, B.C. Reg. 125/2009.

(26b) S. 6.1(7); See policy item #26.22.

(26c) S.6.1(8); See policy item #26.22.

(26d) S.6.2; See policy item #26.22, Emergency Intervention Disclosure Act, S.B.C. 2012, c. 19 and Emergency Intervention Disclosure Regulation, B.C. Reg. 33/2013.

(26e) S.5.1(1.1); See policy item #26.22.

(27) See policy item #95.10, Form of Reports

(28) See policy item #97.10, *Evidence Evenly Weighted*

(29) See Item C10-73.00

(30) S.88(2)

(31) S.88(4)

(32) S.88(5)

(33) S.21, *Evidence Act*

~~(34)~~ ~~S.95(2)~~ **DELETED**

~~(35)~~ ~~See policy item #103.00~~ **DELETED**

(36) See policy item #48.10, *Solicitors' Liens*

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*") has made significant changes to the workers' compensation appeal system.

Prior to the *Amendment Act (No. 2), 2002* being brought into force, the following avenues of appeal existed 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. MRP 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 will continue 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 exist with respect to compensation and rehabilitation matters:

- initial decisions (except decisions on whether to reopen a previous matter) are reviewable by a review officer, who is an officer of the Board;
- most, but not all, review officer decisions are appealable to the independent Workers' Compensation Appeal Tribunal ("WCAT"); and

- initial decisions on whether to reopen a previous matter are directly appealable to WCAT.

In addressing appeals, WCAT may seek independent advice or assistance from a health care professional who appears on a list developed by the WCAT Chair in accordance with the statutory requirements. However, the opinions of the health care professional are not binding upon WCAT.

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 the following website for the *Amendment Act (No. 2), 2002* -

http://www.legis.gov.bc.ca/37th3rd/3rd_read/gov63-3.htm

POLICY

There is no POLICY for this Item.

PRACTICE

Readers should consult the Review Division or WCAT to determine whether a pre-March 3, 2003 decision by the Board or by a previous appeal body is reviewable by the Review Division or appealable to WCAT.

EFFECTIVE DATE:	June 1, 2009 – Delete references to the Medical Review Panel, Review Board and the Appeal Division.
AUTHORITY:	*Workers Compensation Amendment Act (No. 2), 2002*
CROSS REFERENCES:	Reviews and Appeals - Review Division - Practices and Procedures (C13-101.00), Reviews and Appeals - Workers' Compensation Appeal Tribunal (C13-102.00), Reviews and Appeals - Medical Review Panels (C13-103.00), Reviews and Appeals - Transitional Matters Relating to the Review Board and the Appeal Division (C13-104.00).
HISTORY:	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 96.4(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 96(8):

> The Board may establish practices and procedures for carrying out its responsibilities under the Act, including specifying time periods within which certain steps must be taken and the consequences for failing to comply with 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.

PRACTICE

For any relevant PRACTICE information, readers should consult the Review Division's Practices and Procedures available on the WCB website.

EFFECTIVE DATE:	March 3, 2003
AUTHORITY:	ss. 96(8) and 96.4(2), *Workers Compensation Act*
CROSS REFERENCES:	Reviews and Appeals - General (C13-100.00)
HISTORY:	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*, has 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.

With certain exceptions, a final decision made by a review officer in a review under sections 96.2 to 96.5 may be appealed to WCAT.

Those exceptions are:

- a decision respecting matters referred to in section 16 of the *Act*;
- a decision respecting the application under section 23(1) of the *Act* of rating schedules compiled under section 23(2) where the specified percentage of impairment has no range or has a range that does not exceed 5%;
- a decision respecting commutations under section 35;
- a decision respecting an order under Part 3, other than an order
  - relied upon to impose an administrative penalty under section 196(1);
  - imposing an administrative penalty under section 196(1); or
  - made under section 195 to cancel or suspend a certificate; 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. 320/2002), 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 96(8) 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 96.2(4) (extensions of time to request a review);
  - section 96.2(7) (deeming an employers' adviser or an organized group of employers to be the employer);
  - section 96.4(2) (subject to any Board practices and procedures, conducting a review as the review officer considers appropriate);
  - section 96.4(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 96.4(4) (requiring the employer to post a notice in the workplace of reviews relating to certain occupational health and safety matters);
  - section 96.4(5) (suspending a review to allow a review officer to deal with related matters at the same time); and
  - section 96.4(7) (extending the time for a review officer to make a decision);
- an order by the chief review officer under section 96.2(5) 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 96.4(8)(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.

A decision to reopen or not to reopen a matter on an application under section 96(2) may be appealed directly to WCAT.

A determination, an order, a refusal to make an order or a cancellation of an order made by the Board under section 153 (in relation to discriminatory action) may also be appealed directly to WCAT.

2. The Act

The provisions of the *Act* are too extensive to quote in this Chapter. Readers are referred to the following website for the *Amendment Act (No. 2), 2002* -

http://www.legis.gov.bc.ca/37th3rd/3rd_read/gov63-3.htm

POLICY

There is no POLICY for this Item.

PRACTICE

For PRACTICE information about the operation of WCAT, readers should contact WCAT.

EFFECTIVE DATE:	March 3, 2003
AUTHORITY:	ss. 231 to 261, *Workers Compensation Act*; s. 4, *Workers Compensation Act Appeal Regulation* (B.C. Reg. 320/2002)
CROSS REFERENCES:	Reviews and Appeals - General (C13-100.00)
HISTORY:	New Item resulting from the *Workers Compensation Amendment Act (No. 2), 2002*
APPLICATION:	

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 - C14-105.01.

2. The Act

See Items C14-102.01 - C14-105.01.

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 and vocational rehabilitation benefits.

  - Health care benefit entitlement – Section 21 of the *Act* enables the WCB 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 benefit entitlement – Consideration of entitlement to vocational rehabilitation services under section 16 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 services 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 33.1(2) of the *Act*, if a worker's disability continues for ten cumulative weeks of benefits, the WCB 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 section 96 do not limit changes to previous decisions that are required in order to fully implement decisions of the Review Division or the WCAT.

PRACTICE

There is no PRACTICE for this Item.

EFFECTIVE DATE:	June 1, 2009 – Delete reference to officer and replace WCB with Board.
AUTHORITY:	ss. 96(2) - (7), 96.4(9), 255, *Workers Compensation Act*
CROSS REFERENCES:	Changing Previous Decisions - Reopenings (C14-102.01), Changing Previous Decisions - Reconsiderations (C14-103.01), Changing Previous Decisions - Fraud and Misrepresentation (C14-104.01), Changing Previous Decisions - Reviews (C14-105.01), Vocational Rehabilitation – Nature and Extent of Programs and Services (C11-88.00)
HISTORY:	January 1, 2005 – Amendments 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 96:

.....

(2) Despite subsection (1), any time, on its own initiative, or on application, the Board may reopen a matter that has been previously decided by the Board or an officer or employee of the Board under this Part if, since the decision was made in that matter,

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

(b) there has been a recurrence of a worker's injury.

(3) If the Board determines that the circumstances in subsection (2) 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 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 significant change in a worker's medical condition that the Board has previously decided was compensable; or
- there has been a recurrence of a worker's injury.

"A significant change in a worker's medical condition that the Board has 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 a permanent disability award has 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 temporary disability benefits where no permanent disability award was previously provided in respect of the compensable injury; and

- an additional period of temporary disability benefits where a permanent disability award was 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 temporary disability 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 temporary and/or consideration for permanent disability compensation 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 96(2) 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 96(2) 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, vocational 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.

(f) Right to request a review

Section 96.2(2)(g) of the *Act* provides that no request may be made to a review officer under section 96.2(1) to review a decision to reopen or not to reopen a matter on an application for a reopening under section 96(2). Section 240(2) provides that a decision to reopen or not to reopen a matter on an application may be appealed directly to the Workers' Compensation Appeal Tribunal ("WCAT").

The effect of these provisions is that the preliminary or threshold question whether the grounds for a reopening on an application have been met under section 96(2)(a) and (b) may not be the subject of a review by a review officer. A party who wishes to dispute the Board's decision in this respect must appeal directly to the WCAT.

However, where a reopening consideration was undertaken on the Board's own initiative, a request for review of the decision is made to a review officer.

Once it is determined that the grounds for a reopening have been met, the Board's decision on the compensation or rehabilitation to be paid or provided as a result of the reopening may be the subject of a request for a review by a review officer under section 96.2(1). The review officer's decision may then be appealed to the WCAT under section 239(1).

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE: August 1, 2006
AUTHORITY: ss. 96(2), (3), *Workers Compensation Act*

CROSS REFERENCES: Changing Previous Decisions - General (C14-101.01), Changing Previous Decisions - Reconsiderations (C14-103.01), Changing Previous Decisions - Fraud and Misrepresentation (C14-104.01), Changing Previous Decisions - Reviews (C14-105.01)

HISTORY: Consequential amendment to section (d) of policy resulting from changes to 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 made effective August 1, 2006.
Housekeeping amendment to correct numbering effective April 8, 2005.
Amendments effective January 1, 2005 to clarify recurrence of injury and to distinguish between a reopening on application and a reopening on own initiative.
Amendments effective March 18, 2003 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).
New Item consequential to the *Workers Compensation Amendment Act (No. 2), 2002* approved effective March 3, 2003.

APPLICATION: Applies to all decisions on and after January 1, 2005

RE: Changing Previous Decisions – Reconsiderations	ITEM: C14-103.01

BACKGROUND

1. Explanatory Notes

The *Act* provides the Board with a very limited time period to reconsider previous decisions or orders. Subject to certain restrictions, the Board may only reconsider a decision or order under Part 1 of the *Act* during the period of 75 days subsequent to the decision or order being made.

2. The Act

Section 1:

> **"reconsider"** means to make a new decision in a matter previously decided where the new decision confirms, varies or cancels the previous decision or order

Section 96:

> .....
>
> (4) Despite subsection (1), the Board may, on its own initiative, reconsider a decision or order that the Board or an officer or employee of the Board has made under this Part.
>
> (5) Despite subsection (4), the Board may not reconsider a decision or order if
>
> (a) more than 75 days have elapsed since that decision or order was made,
>
> (b) a review has been requested in respect of that decision or order under section 96.2, or
>
> (c) an appeal has been filed in respect of that decision or order under section 240.
>
> …..

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 varied or cancelled, it constitutes a redetermination of those matters.

(b) The purpose of sections 96(4) and (5)

The Board's authority to reconsider previous decisions and orders is found in section 96(4) and (5) of the *Act*. These provisions result from legislative amendments that came into effect on March 3, 2003. The purpose of these amendments is to promote finality and certainty within the workers' compensation system.

The same amendments establish a right to request a review by a review officer under sections 96.2 to 96.5, where a party disagrees with a decision or order 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 and orders of the Board.

It is significant that section 96(4) only authorizes the Board to reconsider a decision or order "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 96(2). It is also to be contrasted with section 96.5 and section 256, which authorize a review officer and the appeal tribunal, respectively, to reconsider decisions on application in certain circumstances.

The use of the words "on own initiative" in section 96(4), with no provision for "on application", and the availability of a review mechanism under sections 96.2 to 96.5, 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 or orders.

Rather, the Board's reconsideration authority is intended to provide a quality assurance mechanism for the Board. The Board is given a time-limited opportunity to correct, on its own initiative, any incorrect decisions it may have made.

(c) Advice to parties

Parties to a decision or order will be advised at the time the decision or order is made, of the right to request a review of the decision or order under section 96.2. A party who approaches the Board to have the decision or order reconsidered will be reminded of the party's right to request a review under section 96.2. If the Board reconsiders a decision or order before the request for review is made, the Board will advise the parties to the decision or order of the reconsidered decision. The reconsidered decision gives rise to a new right to request a review under section 96.2.

(d) Restrictions on reconsideration

The *Act* places a number of express restrictions on reconsidering previous decisions and orders. 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.

- The Board may not reconsider a decision or order more than 75 days after the decision or order was made. This includes all decisions of the Board and officers and employees of the Board made prior to March 3, 2003. The 75 day period commences on the date the decision was made (not March 3, 2003 in the case of those decisions made prior to that date).

- The Board may not reconsider a decision or order if a review has been requested in respect of that decision or order under section 96.2. A request for review under section 96.2 immediately terminates the authority of the Board to reconsider a previous decision or order, even if 75 days has not passed since the decision or order was made.

- The Board may not reconsider a decision or order if an appeal has been filed in respect of that decision or order under section 240. The filing of an appeal under section 240 immediately terminates the authority of the Board to reconsider the decision or order, even if 75 days has not passed since the decision or order was made.

There are, in addition, a number of implicit restrictions on reconsidering previous decisions and orders. 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 256 of the *Act* provides for the Workers' Compensation Appeal Tribunal 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 reconsideration

Subject to the limitations set out above, the Board may reconsider a decision on its own initiative where:

- there is new evidence indicating that a prior decision or order 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 clearly incorrectly, or
  - not applying an applicable policy; or
- there has been a clear error of law, such as a failure by the Board to follow the express terms of the *Act*.

(f) Authority of Board officers, Managers and Directors to reconsider

A Board officer may only reconsider a decision made by another Board officer where there is new evidence, a mistake of evidence, a policy error or a clear error of law.

A Manager or Director may reconsider a decision or order made by a Board officer in any of these circumstances, and may also reweigh the evidence and substitute his or her own judgment for that of the Board officer.

(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, slips or omissions 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 accidental slip or omission 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 errors, slips or omissions, however, cannot be applied to change decisions.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website at worksafebc.com.

EFFECTIVE DATE:	April 1, 2010 – Delete reference to providing written communication of rights of review.
AUTHORITY:	ss. 96(4), (5), *Workers Compensation Act*
CROSS REFERENCES:	Changing Previous Decisions - General (C14-101.01), Changing Previous Decisions - Reopenings (C14-102.01), Changing Previous Decisions - Fraud and Misrepresentation (C14-104.01), Changing Previous Decisions - Reviews (C14-105.01)
HISTORY:	June 1, 2009 – Delete 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. 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 to all decisions made on or after April 1, 2010.

RE: Changing Previous Decisions – Fraud and Misrepresentation	ITEM: C14-104.01

BACKGROUND

1. Explanatory Notes

Section 96(7) allows the Board to set aside any decision or order under Part 1 that has resulted from fraud or misrepresentation.

2. The Act

Section 96:

(7) Despite subsection (1), the Board may at any time set aside any decision or order made by it or by an officer or employee of the Board under this Part if that decision or order resulted from fraud or misrepresentation of the facts or circumstances upon 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.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WCB website.

EFFECTIVE DATE:	March 3, 2003
AUTHORITY:	s. 96(7), *Workers Compensation Act*
CROSS REFERENCES:	Changing Previous Decisions - General (C14-101.01), Changing Previous Decisions - Reopenings (C14-102.01), Changing Previous Decisions - Reconsiderations (C14-103.01), Changing Previous Decisions - Reviews (C14-105.01)
HISTORY:	New Item consequential to the *Workers Compensation Amendment Act (No. 2), 2002*
APPLICATION:	Applies to all decisions on and after March 3, 2003

RE: Changing Previous Decisions – Reviews **ITEM: C14-105.01**

BACKGROUND

1. Explanatory Notes

Sections 96.2 to 96.5 provide a right of review in respect of certain decisions made by Board officers.

2. The Act

Section 96:

(6) Despite subsection (1), the Board may review a decision or order made by the Board under this Part or by an officer of employee of the Board under this Part but only as specifically provided in sections 96.2 to 96.5.

POLICY

There is no POLICY for this Item.

PRACTICE

For any relevant PRACTICE information, readers should consult the Review Division's Practices and Procedures available on the WCB website.

EFFECTIVE DATE:	March 3, 2003
AUTHORITY:	s. 96(6), *Workers Compensation Act*
CROSS REFERENCES:	Changing Previous Decisions - General (C14-101.01), Changing Previous Decisions - Reopenings (C14-102.01), Changing Previous Decisions - Reconsiderations (C14-103.01), Changing Previous Decisions - Fraud and Misrepresentation (C14-104.01)
HISTORY:	New Item consequential to the *Workers Compensation Amendment Act (No. 2), 2002*
APPLICATION:	Applies to all decisions on and after March 3, 2003

CHAPTER 15

ADVICE AND ASSISTANCE

#109.00 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.

EFFECTIVE DATE: June 1, 2009 – Delete references to Adjudicators, Claims Officer and Board officer.
APPLICATION: Applies on or after June 1, 2009

#109.10 Workers' Advisers

The duties of Workers' Advisers are to:

1. give assistance to a worker or to a dependant having a claim, except where a Workers' Adviser thinks the claim has no merit;

2. on claims matters, communicate with or appear before the Board or the Workers' Compensation Appeal Tribunal on behalf of a worker or dependant where an Adviser considers assistance is required; and

3. advise workers and dependants with regard to the interpretation and administration of the *Act* or any regulations or decisions made under it. (1)

A Workers' Adviser and staff shall have access at any reasonable time to the complete claims files of the Board and any other material pertaining to the claim of an injured or disabled worker; but the information contained in those files shall be treated as confidential to the same extent as it is so treated by the Board. (2)

EFFECTIVE DATE: March 3, 2003 (as to reference to the Workers' Compensation Appeal Tribunal)
APPLICATION: Not applicable.

#109.20 Employers' Advisers

The duties of an Employers' Adviser is to:

1. give assistance to an employer respecting any claim of

   (a) a worker, or

   (b) a dependant of a worker

   of that employer, except where an Employers' Adviser thinks the claim has no merit;

2. on claims matters, communicate with or appear before the Board or the Workers' Compensation Appeal Tribunal on behalf of an employer where an Adviser considers assistance is required; and

3. advise employers with regard to the interpretation and administration of the *Act* or any regulations or decisions made under it. (3)

An Employers' Adviser and staff have the same right of access to the Board's claim files as a Workers' Adviser and is subject to the same obligation of confidentiality. (4) In addition, section 94(5) 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: March 3, 2003 (as to reference to the Workers' Compensation Appeal Tribunal)

APPLICATION: Not applicable.

#109.30 Ombudsman

The Ombudsman has the right to examine or copy material from claim files in the possession of the Board.

The Board regards the work of the Ombudsman'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 Ombudsman's office in all matters.

NOTES

(1) s.94(2)
(2) s.95(3)
(3) s.94(3)
(4) s.95(3)

CHAPTER 16

THIRD PARTY/OUT-OF-PROVINCE CLAIMS

#110.00 INTRODUCTION

A worker who suffers injury or disease as a result of employment may be entitled to compensation from sources other than the Workers' Compensation Board. The *Act* makes special provision in section 10 for injuries or diseases which occur in circumstances entitling the worker to pursue an action for damages against a third party.

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.

#111.00 THIRD PARTY CLAIMS

#111.10 Injury Caused by Worker or Employer

Section 10(1) of the *Act* provides that "The provisions of this Part are in lieu 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, dependant or member of the family of the worker is or may be entitled against the employer of the worker, or against any employer within the scope of this Part, or against any worker, in respect of any personal injury, disablement or death arising out of and in the course of employment and no action in respect of it lies. This provision applies only when the action or conduct of the employer, the employer's servant or agent, or the worker, which caused the breach of duty arose out of and in the course of employment within the scope of this Part."

This provision prohibits a law suit by an injured worker or a dependant of an injured worker against the employer of the worker or against any employer within the scope of Part 1 of the *Act*, or against any worker in respect of any personal injury, disablement, or death arising out of and in the course of the employment. The worker or dependant 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 his or her employment.

#111.11 Employer or Worker Partly at Fault

If, in any action brought by a worker or dependant of a worker or by the Board, it is found that the injury, disablement, or death, as the case may be, was due partly to a breach of duty of care of one or more employers or workers under the *Act*, no damages, contributions, or indemnity are recoverable for the portion of the loss or damage caused by the negligence of such employer or worker; but the portion of the loss or damage caused by that negligence shall be determined although the employer or worker is not a party to the action. (1)

#111.20 Injury Not Caused by Worker or Employer

Section 10(2) provides that "Where the cause of the injury, disablement or death of a worker is such that an action lies against some person, other than an employer or worker within the scope of this Part, the worker or dependant may claim compensation or may bring an action. If the worker or dependant elects to claim compensation, he or she must do so within 3 months of the occurrence of the injury or any longer period that the board allows."

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 10(1), the action against the owner may still lie, with the result that the claimant must make an election under section 10(2). This could occur, for example, where the owner takes her or his 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 10(2), 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 10(1) if she or he is an employer covered by the *Act*, but not if she or he is located outside the province.

#111.21 Competence to Make Election

Where the Board is satisfied that due to a physical or mental disability a worker is unable to exercise the right of election, and undue hardship will result, it may pay compensation until the worker is able to make an election. If the worker then elects not to claim compensation, no further compensation may be paid, but the compensation so paid is a first charge against any sum recovered. (2)

An application filed by a parent, guardian, or the official guardian for compensation for the infant child of a deceased worker is a valid election on behalf of that child. (3)

A worker under the age of 19 years can make a valid election. (4)

#111.22 Form of Election

Any signed notification from a worker or dependant outlining her or his decision is a valid election. A Form 6 Application for Compensation (5) 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.

#111.23 Election Not to Claim Compensation

If an injured worker decides to proceed with a law suit, no action is taken on the claim by the Board. The worker simply retains a lawyer to prosecute the case.

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 the worker or dependant would be entitled under the *Act*, the worker or dependant is entitled to compensation to the extent of the amount of the difference. (6) Therefore, if a worker fails in the law suit 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 he or she 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 10(5), 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. (7)

#111.24 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.

Section 10(6) provides in part that "If the worker or dependant applies to the board claiming compensation under this Part, neither the making of the application nor the payment of compensation under it restricts or impairs any right of action against the party liable, but as to every such claim 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; . . ."

A person cannot therefore claim both compensation benefits and pursue a court action. 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 policy item #111.21, a claimant receives compensation prior to making an election, the compensation is terminated immediately that an election is made not to claim compensation.

Pre-conditions also exist in the case of an emergency service worker's ability to receive compensation. No compensation is payable to the Emergency Services Worker or legal representative or dependant, as the case may be, unless he or she:

(a) assigns and subrogates or assign and subrogate to the Workers' Compensation Board his or her 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 Her Majesty's Armed Forces from any and all liability arising out of or connected with the said accident.

#111.25 Pursuing of Subrogated Actions by the Board

Where the Board is subrogated to an action following a claimant's election to claim compensation, it 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. (8) 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, he or she 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 his or her own. It is expressly provided in section 10(10) that "In an action brought under this section, an award for damages is to include

(a) health care provided under this Part; and

(b) wages and salary paid by an employer during the period of disability for which regard has been had by the board, or would have been had if the worker had elected to claim compensation, in fixing the amount of a periodical payment of 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.

Costs may, notwithstanding that a salaried employee of the Board acts as its solicitor or counsel, be awarded to and collected by the Board in any action taken by the Board. (9)

Section 10(6) provides in part that ". . . if more is recovered and collected than the amount of the compensation to which the worker or dependant would be entitled under this Part, the amount of the excess, less costs and administration charges, must be paid to the worker or dependant." Thus, if the action is successful, the Board's disbursements, i.e. the amounts it has paid for wage-loss compensation and health care benefits together with administration costs, 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.

There are particular rules applicable when an action that is pursued arises out of an accident suffered by an Emergency Services Worker. The Provincial Emergency Program agreement states, "Where compensation or health care (hereinafter "compensation") is paid or provided and the Workers' Compensation Board has, pursuant to subrogation from the person claiming compensation as an Emergency Services Worker or from his legal representative or his dependents, (sic) as the case may be, to whom compensation is paid, recovered an amount from any person with respect to the said accident, the Workers' Compensation Board shall reimburse Canada and B.C. in an amount that bears the same relation to the amount so recovered, less reasonable costs and reasonable administration expenses, as the amount paid by Canada and B.C. bears to the amount of the compensation determined."

#111.26 Failure to Recover Damages

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 a permanent disability award where the indebtedness may be recovered from the permanent disability award capital reserve.

#111.30 Meaning of "Worker" and "Employer" under Section 10

In the provisions discussed in policy items #111.10 to #111.24, "worker" and "employer" have the meaning given to them in Chapter 2.

For the purpose of section 10, "worker" includes an employer entitled to personal optional protection. (10) However, this does not affect status as an employer under this section in regard to other workers.

The meanings of "employer", "worker", and "employment" for the purpose of section 10 in claims concerning commercial fishers are discussed in section 14 of the *Fishing Industry Regulations*.

EFFECTIVE DATE: March 18, 2003 (as to the deletion of reference to the *Workers' Compensation Reporter* Decision No. 223)

APPLICATION: Not applicable.

#111.50 Federal Government Employees

The provisions discussed in policy items #111.00 – #111.30 above have no application to employees entitled under the *Government Employees Compensation Act*.

Rules similar to those set out in policy items #111.00 – #111.30 are set out in section 9 of that *Act*. 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.

#112.00 INJURIES OCCURRING OUTSIDE THE PROVINCE

Section 5(1) provides in part that compensation is payable where ". . . personal injury or death arising out of and in the course of the 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 the province. 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 the province 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 items #112.10 and #112.20.

The payment of health care benefits for costs incurred outside the province is discussed in Item C10-75.10, *Health Care Accounts – Health Care Provided Out-of-Province*.

#112.10 Claimant is Working Elsewhere than in the Province

Section 8(1) provides that "Where the injury of a worker occurs while the worker is working elsewhere than in the Province which would entitle the worker or the worker's dependants to compensation under this Part if it occurred in the Province, the board must pay compensation under this Part if

(a) a place of business of the employer is situate in the Province;

(b) the residence and usual place of employment of the worker are in the Province;

(c) the employment is such that the worker is required to work both in and out of the Province; and

(d) the employment of the worker out of the Province has immediately followed the worker's employment by the same employer within the Province and has lasted less than 6 months,

but not otherwise."

Section 8 does not apply to commercial fishers.

#112.11 Meaning of Working in Section 8

Section 8(1) only applies "Where the injury of a worker occurs while the worker is working elsewhere than in the Province . . ."

In a Board decision, a claimant who lived in the province of Alberta was employed by an employer located in the province. Each day, he travelled into the province 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 the province rather than the province of Alberta with the result that section 8 had no application.

The Board has on prior occasions, when discussing the meaning of the phrase "arising out of and in the course of the employment" in section 5(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 the "employment". (11) This distinction between "employment" and "work" activities is also material when interpreting section 8(1). 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 claimant 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 claimant was required to perform some incidental job function outside the province. Under this interpretation, the concern is not with the particular activity being carried on at the moment of injury, but the place where the claimant performs the major job functions with which that activity is associated.

In other cases, the interpretation of section 8(1) adopted above may raise difficult questions as to whether a claimant's main job function at the time in question is in the province or elsewhere. There will be less obvious cases where the claimant is performing significant amounts of productive work activity both inside and outside the province. Since section 8(1) clearly contemplates that there will be periods of work outside the province where the claimant 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 this province and productive activities which are sufficient to constitute "working elsewhere".

In making this judgment, regard will primarily have to be taken of the length of time for which the productive activity is performed outside the province. 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 the province. On the other hand, where the length of time is greater than a week, it would probably have to be concluded that the claimant was "working elsewhere than in the Province". 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 claimant's employment.

Another factor that must be considered is the degree of regularity with which a claimant does productive work outside the province. The more regularly this is done, the shorter is the period of productive work outside the province which would be sufficient for the claimant to be considered as "working elsewhere". For example, even though the period out of the province is less than a day, the claimant might be held to be working outside the province if this was done routinely.

#112.12 Residence and Usual Place of Employment

Section 8 of the *Act* was intended to provide a convenient and efficient form of coverage for industries which, although normally based in this province, may occasionally require assignment of workers to locations outside the province. 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 the province, virtually all of that company's work takes place outside of the province 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 8, 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 claimant's employer had its head office and base of operations in this province. The claimant underwent a two-week training period at the head office, but all his work was outside of the province. The claimant lived primarily in Ontario and had rented no accommodation in this province 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.

#112.13 Employment of the Worker out of the Province has Immediately Followed Employment by the same Employer within the Province and has Lasted less than Six Months

Upon first reading, section 8(1)(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-province" and those "out-of-province". It requires that employment out-of-province must last less than six months and must immediately follow employment by the same employer within the province; but it makes no reference to where, outside the province, 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 will not have been employed by the same employer within the province immediately prior to going to the other jurisdiction and 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 the province and, due to the absence of any further employment prospects, be laid off and then hire on again within the province 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.

#112.20 Claimant is Working in the Province

The decision discussed in policy item #112.11 provides an example of when a claimant might be working in the province but yet injured outside the province while in the course of his employment. Though the provisions of section 8(1) were not applicable to that claim, it was decided that the claim could be accepted under section 5(1).

Where there is an out-of-province injury, the first question that must be asked is where, at the time in question, the claimant was performing his main job functions. The concern will not be with the particular activity being engaged in at the moment of the injury. If the claimant's main job at the time is being performed outside of the province, the claim must satisfy the requirements of section 8(1), including the requirement that he be a resident of the province. If those functions are being performed in the province, he only has to meet the requirements of section 5(1) and section 8(1) has no application. Since the main job function of the claimant in this decision was in the province 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 the province.

#112.30 Workers Also Entitled to Compensation in Place of Injury

Section 9(1) provides in part that "Where by the law of the country or place in which the injury or occupational disease occurs the worker or the worker's dependants are entitled to compensation in respect of it, they must elect whether they will claim compensation under the law of that country or place or under this Part, and to give notice of the election. If the election is not made and notice given, it must be presumed that they have elected not to claim compensation under this Part; . . ."

The right of election is subject to the terms of any interjurisdictional agreement. (12)

Notice of the election must be given to the Board within three months after the occurrence of the injury or disablement from occupational disease, or, if it results in death, within three months after the death, or within any longer period that either before or after the expiration of the three months the Board allows. (13)

In addition to the election form noted above, a Form 6 Application for Compensation is also required. A claim for compensation, made to the Workers' Compensation Board of the place where the injury or exposure to the causes of an occupational disease occurs, constitutes an election to claim under the law of that place.

#112.31 Occupational Disease

It may happen that the occupational disease suffered by a worker is due to exposure in the course of employment both inside and outside the province. If the exposure within the province is not significant, the Board will not accept responsibility for the claim, subject to the terms of any interjurisdictional agreement. If the exposure within the province is significant, the Board will accept responsibility of the whole of the worker's problem. There will, in general, be no apportionment of liability. The worker may, however, be required to elect to claim in this province under section 9(1). Where the Board is accepting full responsibility for the condition, the worker cannot claim in both this province and another province or territory.

An exception exists for hearing-loss claims. As discussed in policy item #31.20, liability will be apportioned where more than 5% but under 90% of the claimant's exposure was outside the province.

#112.40 Federal Government Employees

Federal Government employees must claim compensation in the province where they are usually employed regardless of the place of injury. (14)

NOTES

(1) S.10(7)

(2) S.10(3)

(3) S.10(4)

(4) S.12; policy item #49.00, *Incapacity of a Worker*

(5) policy item #93.20, *Application for Compensation*

(6) S.10(5)

(7) policy item #93.20, *Application for Compensation*

(8) S.10(6)

(9) S.10(11)

(10) S.10(9); S.3(3)

(11) See Item C3-14.00, *Arising Out of and In the Course of the Employment*

(12) See policy item #113.30, *Interjurisdictional Agreements*

(13) S.9(2)

(14) Item C3-12.10, *Federal Government Employees*

CHAPTER 17

CHARGING OF CLAIM COSTS

#113.00 INTRODUCTION

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, and the Provincial Government. 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: December 31, 2003 (as to the third paragraph which incorporates portions of, and replaces, policy item #115.20 *"Significance of Employer's Conduct in Producing Injury"* of this manual.)

#113.10 Investigation Costs

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 on suffering an occupational disease at policy item #26.10.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Medical Review Panel, officer, Manager and Director.
HISTORY:	March 3, 2003 – Insert 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

#113.20 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 and health care benefits are 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 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 is then made and an apportionment of the costs incurred beyond 13 weeks, including the amount of any permanent disability award 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 13 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.

   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 award 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, where any portion attributable to any employer at the time the claim is submitted is less than 20%, the costs incurred following 13 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 is sent to the employers' association that best represents the appropriate class and subclass of industry.

   Effective September 28, 2002, where 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 is 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.

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

#113.21 Silicosis and Pneumoconiosis

When, in the case of silicosis or pneumoconiosis claims, there is exposure to silica or other dust in more than one subclass of industry within the Province, 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 resume 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 is therefore responsible for handling silicosis or pneumoconiosis claims discretion in the apportionment of costs 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 or other dust.

2. Where confirmed employment records are unavailable, but there is other substantive evidence to support periods of exposure to silica or other dust, the Board has discretion to apportion costs on the basis of the best evidence available.

3. Where a worker is entitled to compensation for silicosis or pneumoconiosis under the terms of section 6 of the *Act*, the costs will be charged to the appropriate class or classes of industry within the province of British Columbia as provided by the *Act*.

EFFECTIVE DATE: June 1, 2009 – Delete references to Board officer.
APPLICATION: Applies on or after June 1, 2009

#113.22 Hearing-Loss Claims

Section 7(7) of the *Act* provides that "Where a worker suffers loss of hearing caused by exposure to causes of hearing loss in 2 or more classes or subclasses of industry in the Province, 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."

The procedure followed to implement this provision 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. Where 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. Where the total exposure in this province is 5% or less, the claim is disallowed. Where the total exposure in this province is 90% or greater, the Board accepts responsibility for the whole hearing loss.

4. Where 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. (1)

#113.30 Interjurisdictional Agreements

Section 8.1(1) provides as follows:

"The board may enter into an agreement or make an arrangement with Canada, a province or the appropriate authority of Canada or a province to provide for

(a) compensation, rehabilitation and health care to workers in accordance with the standards established under this Act or corresponding legislation in other jurisdictions,

(b) administrative co-operation and assistance between jurisdictions in all matters under this Act and corresponding legislation in other jurisdictions, or

(c) avoidance of duplication of assessments on workers' earnings."

The agreement entered into 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 this province may be required to register with this Board as an employer even though carrying on business and is registered as an employer with the Board in another province or territory. (2)

Where an employee of such an employer suffers from 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.

#114.00 PROVISIONS RELIEVING CLASS OF COSTS OF CLAIM

#114.10 Transfer of Costs from One Class to Another

Section 10(8) provides as follows:

> "The provisions of this Part are in lieu of any right of action that the employer of the injured or deceased worker is or may, in respect of the personal injury or death of the worker, be entitled to maintain against another employer within the scope of this Part, or an independent operator to whom this Part applies by direction under section 2(2)(a); but where the board considers that
>
> (a) a substantial amount of compensation has been awarded as a result of the injury or death of the worker; and
>
> (b) the injury or death was caused or substantially contributed to by a serious breach of duty of care of an employer or an independent operator to whom this Part applies by direction under section 2(2)(a) in another class or subclass,
>
> the board may order that the compensation be charged, in whole or in part, to the other class or subclass; but the provisions of this subsection do not affect any right which an employer may have against another employer, or an independent operator to whom this Part applies by direction under section 2(2)(a), arising out of their indemnity agreement or contract."

This provision 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.

#114.11 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, 2018 – December 31, 2018	$49,298.50
January 1, 2019 – December 31, 2019	$50,503.66

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 25.2 of the *Act*, as described in policy item #51.20, will be used.

#114.12 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 10(8), and a transfer of costs is only available where 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.

#114.13 Discretion of the Board

The Board has a discretion where the requirements set out in policy items #114.10 – 12 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.

#114.20 Depletion or Extinction of Industries or Classes

Section 39(1)(b) 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.

#114.30 Disasters or Other Circumstances which Unfairly Burden a Rate Group

Section 39(1)(d) requires the Board to "provide a reserve … to meet the loss arising from a disaster or other circumstances which the Board considers would unfairly burden the employers in a class."

Costs will not be charged to the fund created by section 39(1)(d) 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 39(1)(d) 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:	March 1, 2005
HISTORY:	Updates language, consistent with rate-making system in *Assessment Manual*; incorporates portions of, and replaces, 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:	Applies to all decisions on and after March 1, 2005

#114.40 Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability

1. Overview

Section 39(1)(e) 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 experience rating and rate group to the section 39(1)(e) reserve.

The intent of section 39(1)(e) 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.

Where a claim is accepted under the *Act* for a personal *injury*, mental disorder or occupational disease, the Board provides cost relief under section 39(1)(e) for any portion of a compensable *disability* that is enhanced by reason of a pre-existing disease, condition or disability. Section 39(1)(e) cost relief decisions do not impact a worker's entitlement to compensation.

The Board is responsible for initiating section 39(1)(e) 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.

2. Eligibility

Cost relief consideration does not occur on claims where wage loss ended and/or a permanent disability award was established on or before December 31, 1993.

Where benefits were paid between January 1, 1994 and September 27, 2002, an employer was eligible for cost relief consideration under section 39(1)(e) 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) a permanent disability award had been granted.

Where benefits are paid on or after September 28, 2002, an employer is eligible for cost relief consideration under section 39(1)(e) 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) a permanent disability award has 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.

3. 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 39(1)(e).

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 39(1)(e).

If a worker suffers a compensable personal injury (including mental disorder or occupational disease), and there is no evidence of any pre-existing disease, condition or disability, section 39(1)(e) 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 39(1)(e).

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.

Where 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 39(1)(e) will clearly be applicable.

3. *How severe was the incident initiating the claim in question?*

Where 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 39(1)(e) will not normally be applicable.

Since section 39(1)(e) specifically refers to the enhancement of "disability", it has no application in fatal cases or in cases where only health care benefits are payable.

4. 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 39(1)(e) can never be more than an estimate and will always be difficult to determine.

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

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

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

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

In respect of permanent disability awards, it is necessary for the 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 a permanent disability award, as this would imply that no portion of the permanent disability resulted from the work-related injury.

5. <u>Timing of Cost Relief Decisions</u>

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

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

b) the conclusion of temporary disability compensation; or

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

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

6. Communication of Cost Relief Decisions

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

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

EFFECTIVE DATE:	March 1, 2005
CROSS-REFERENCES:	Medical Evidence (policy item #97.30) Appeal and Review Rights (section 41(1)(a)(i), *Workers Compensation Amendment Act (No. 2), 2002*, S.B.C. 2002, c. 66)
HISTORY:	Housekeeping amendment effective April 8, 2005. Combines and replaces policy items #114.40A, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*, #114.40B, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*, #114.43, *Procedure Governing Applications under Section 39(1)(e)*, and #114.50, *Sections 39(1)(d), 39(1)(e) and Federal Government Claims* of this *Manual*. Incorporates policy previously set out in Panel of Administrators' Resolution No. 1998/04/23-03 *Re: Section 39(1)(e)*. Section 39(1)(e) cost relief consideration does not occur on claims where wage loss ended and/or a permanent disability award was established on or before December 31, 1993. On or after July 1, 1998, section 39(1)(e) cost relief consideration is available for claims in which the pre-existing disease, condition or disability arises from an earlier compensable injury or disease with the same employer as the compensable injury or disease for which relief is sought.

Incorporates portions of, and retires from policy status, *Workers' Compensation Reporter* Decision No. 271, [1971] 4 W.C.R. 10.

Further amendments clarify the evaluation process for allocating cost relief.

This policy continues the substantive requirements as they existed prior to the effective date.

APPLICATION: Applies to all decisions on and after March 1, 2005

#114.41 Relationship Between Sections 5(5) and 39(1)(e)

It is important to distinguish between the provisions of section 5(5) and section 39(1)(e), as discussed in policy items #44.00 and #114.40. Section 5(5) 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. (As outlined in policy item #44.31**,** section 5(5) can also apply if a permanent disability award is being assessed on a loss of earnings basis under section 23(3) of the *Act* and the disability is deemed to be partly the result of a disability in another part of the body.) It may result in a reduction in the amount of compensation paid to the worker.

Section 39(1)(e) 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 5(5) does not apply and the whole of the worker's disability results from the injury or, if section 5(5) 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 when 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.

EFFECTIVE DATE: March 1, 2005

HISTORY: Updates language, consistent with rate-making system in *Assessment Manual*.

This policy continues the substantive requirements as they existed prior to the effective date.

APPLICATION: Applies to all decisions on and after March 1, 2005

#114.42 Application of Section 39(1)(e) to Occupational Diseases

Section 39(1)(e) 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 policy item #113.20. However, there may be cases where the disability caused by an occupational disease was enhanced by a pre-existing condition. Section 39(1)(e) can be applied in such cases if the criteria outlined in policy item #114.40 are met.

#115.00 PROVISIONS CHARGING INDIVIDUAL EMPLOYERS

One provision of this nature has been discussed in policy item #94.15. Section 54(8) permits the Board to charge an employer with the costs of a claim where late in submitting a report of injury to the Board.

Other provisions of this nature are discussed below.

#115.10 Failure to Register as an Employer at the Time of Injury

Where 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 AP1-1-4 of the *Assessment Manual* apply. However, the employer may be faced with paying the costs of the claim under section 47(2), which provides as follows:

> An employer who refuses or neglects to make or transmit a payroll return or other statement required to be furnished by the employer under section 38(1), or who refuses or neglects to pay an assessment, or the provisional amount of an assessment, or an instalment or part of it, 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 any injury or occupational disease to a worker in the employer's employ which happens during the period of that default, and the payment of the amount may be enforced in the same manner as the payment of an assessment may be enforced.

Section 38(1) provides that “Every employer must

(a) keep at all times at some place in the Province, the location of which the employer has given notice to the Board, complete and accurate particulars of the employer's payrolls;

(b) cause to be furnished to the Board

(i) when the employer becomes an employer within the scope of this Part; and,

(ii) at other times as required by a regulation of the Board of general application or an order of the Board limited to a specific employer, an estimate of the probable amount of the payroll of each of the employer's industries within the scope of this Part, together with any further information required by the Board; and

(c) furnish certified copies of reports of the employer's payrolls, at or after the close of each calendar year and at the other times and in the manner required by the Board."

The Board may, under section 47(3), if satisfied that the default was excusable, relieve an employer in whole or in part from liability under section 47(2).

The Board has decided that section 47(2) applies to claims for fatalities.

The charge made under section 47(2) 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.

Policy item #113.30 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. Where such an employer is not registered in this province at the time of an injury, there may be personal liability for the costs of the claim under section 47(2) in any situation where, under the provisions of the Interjurisdictional Agreement or otherwise, the employer's class would ordinarily be charged.

EFFECTIVE DATE: March 18, 2003 (as to numerical reference to the policy in Item AP1-1-4 in the *Assessment Manual*)

APPLICATION: Not applicable.

#115.30 Experience Rating Cost Exclusions

Section 42 provides as follows.

> The Board shall establish subclassifications, differentials and proportions in the rates as between the different kinds of employment in the same class as may be considered just; and where the Board thinks a particular industry or plant is shown to be so circumstanced or conducted 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 must confer

or impose on that industry or plant a special rate, differential or assessment to correspond with the relative hazard or cost of compensation of that industry or plant, and for that purpose may also adopt a system of experience rating.

The Board has adopted an experience rating plan (ER) under this section. 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 ER can be found in the policy in Item AP1-42-1 of the *Assessment Manual*.

As a general rule, all acceptable claims coded to a particular employer are counted for experience rating 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 policy item #111.25, *Pursuing of Subrogated Actions by the Board*).

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 policy item #113.10, *Investigation Costs*).

3. Costs transferred to the rate group of another employer under section 10(8) (see policy item #114.10, *Transfer of Costs from One Class to Another*).

4. Costs assigned to the funds created by section 39(1)(d) and (e) (see policy item #114.30, *Disasters or Other Circumstances which Unfairly Burden a Rate Group*, and policy item #114.40, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*).

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 policy item #113.20, *Occupational Diseases*)

6. Until September 27, 2002, costs after 13 weeks where section 5(3) applies (see Item C3-14.10, *Serious and Wilful Misconduct*). Effective September 28, 2002, costs after 10 weeks where section 5(3) applies (see Item C3-14.10, *Serious and Wilful Misconduct*).

7. Costs from accidents substantially due to personal illness, e.g. epilepsy (see Item C3-16.00, *Pre-Existing Conditions or Diseases*).

8. Injuries covered by Items C11-88.10, *Work Assessments*, C11-88.40, *Training-on-the-Job*, and C11-88.50, *Formal Training*.

9. The situations covered by policy item #115.31, *Injuries or Aggravations Occurring in the Course of Treatment, Surgery and Board-related Appointment, or Travel Thereto,* and policy item #115.32, *Claims Involving a Permanent Disability Award and a Fatality*, below.

10. The situation covered by policy item #115.33, *Claims Relating to Subsequent Non-Compensable Incidents*.

11. 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 item #115.34, *Experience Rating Exclusions for Certain Compensable Consequences*.

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: January 1, 2016

HISTORY: 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 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 – Delete**d** 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 policy items #113.20 and 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 Item AP1-42-1 in the *Assessment Manual* were incorporated.

APPLICATION: This policy applies to all decisions made on or after January 1, 2016.

#115.31 Injuries or Aggravations Occurring in the Course of Treatment, Surgery, and Board-related Appointment, or Travel Thereto

Where 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 experience rating will only occur where:

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, and

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 21(3) (see Item C10-83.30, *Date of Injury Transportation*), and

3. the aggravation or subsequent injury resulted in permanent disability or death.

The application of relief is limited to the permanent disability award 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 experience rating 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 – expanding policy to include "surgery", "Board-related appointment", and "travel for exceptional medical treatment or examination".
AUTHORITY:	Section 42 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*; Policy item #115.30, *Experience Rating Cost Exclusions*; Policy item #115.34, *Experience Rating Exclusions for Certain Compensable Consequences*.
HISTORY:	Policy amended effective January 1, 2016 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 made effective, arising from changes to 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 – Amendments to delete references to the Review Board and the Appeal Division. June 30, 2002 – Housekeeping changes made to update terminology.
APPLICATION:	This policy applies to all decisions made on or after January 1, 2016.

#115.32 Claims Involving a Permanent Disability Award and a Fatality

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 a permanent disability award may die as a result of the injury or disease accepted under the claim. If pensions are payable to dependants, the cost otherwise included in ER may be reduced to the extent set out below:

1. Where the average cost of a fatal award is the same or less than that of the permanent disability award, the total cost of the fatal award is excluded.

2. Where the average cost of a fatal award is greater than that of the permanent disability award, a portion of the cost of the fatal award equal to the reserve charged to the employer for the permanent disability award is excluded.

#115.33 Claims Relating to Subsequent Non-Compensable Incidents

A worker may continue to receive temporary wage-loss benefits where recovery from a compensable disability is delayed due to a subsequent non-compensable incident.

As set out in policy item #34.55, 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 or the subsequent non-compensable incident. If the disability is due to the compensable injury, wage-loss benefits may be continued.

Where 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 wage-loss benefits is excluded from the employer's experience rating. These costs will also not be charged to the employer's rates group, but will be spread across all rate groups.

Claims costs associated with a permanent disability award would not be relieved under this policy.

EFFECTIVE DATE: August 1, 2010
APPLICATION: This policy applies to all decisions made on or after August 1, 2010.

#115.34 Experience Rating Exclusions for Certain Compensable Consequences

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, *Compensable Consequences*, 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 experience rating.

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 experience rating.

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 experience rating:

- the costs arising from injuries or aggravations that occur during the course of Board-sponsored work assessments described in Item C11-88.10, *Vocational Rehabilitation – Work Assessments*;
- the costs of certain employment injuries and aggravations occurring in the course of training-on-the-job programs described in Item C11-88.40, *Vocational Rehabilitation – Training-on-the-Job*; 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, *Vocational Rehabilitation – Formal Training*.

B. TRAVEL TO PLACES OF TREATMENT, SURGERY, APPOINTMENT, AND VOCATIONAL REHABILITATION

As set out in Section A of Item C3-22.10, *Compensable Consequences – Travel*, 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, *Compensable Consequences – Travel* 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 experience rating.

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 experience rating, 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 experience rating 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 experience rating for permanent disability or fatal awards under policy item #115.31, *Injuries or Aggravations Occurring in the Course of Treatment, Surgery, and Board-related Appointment, or Travel Thereto*

EFFECTIVE DATE:	January 1, 2016
AUTHORITY:	Section 42 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*; Policy item #115.30, *Experience Rating Cost Exclusions*; Policy item #115.31, *Injuries or Aggravations Occurring in the Course of Treatment, Surgery, and Board-related Appointment, or Travel Thereto*.
HISTORY:	This new policy was approved and brought into effect by BOD Resolution No. 2015/05/27-03.
APPLICATION:	This policy applies to all claims for injuries that occur on or after January 1, 2016.

NOTES

(1) See policy item #31.20

(2) See Item AP1-38-4 of the *Assessment Manual*

~~(3) See policy item #112.30~~ **DELETED**

~~(4) See policy item #82.40~~ **DELETED**

~~(5) See policy item #82.40~~ **DELETED**

~~(6) S.96(6) and 96(7)~~ **DELETED**

RE: Retirement Benefits Establishment of Amounts Set Aside and Contributed **ITEM: C18-116.00**

BACKGROUND

1. Explanatory Notes

The *Act* as amended by the *Amendment Act, 2002* establishes 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 his or her permanent disability on his or her ability to accumulate retirement savings.

Under section 23.2 of the *Act*, the Board sets aside an amount toward the establishment of a retirement benefit. A worker may also apply to the Board to contribute a portion of their permanent disability periodic payments in addition to the amounts set aside by the Board.

2. The Act

Section 23.2:

(1) This section applies to a worker who is receiving periodic payments under section 22(1) or 23(1) or (3).

(2) The Board must set aside, at the time a periodic payment is made to a worker, an amount that

(a) is equal to 5% of the periodic payment, and

(b) is in addition to the periodic payment.

(3) A worker may apply to the Board to contribute to the amount set aside or to be set aside under subsection (2) an amount that is not less than 1% and not greater than 5% of each subsequent payment made to the worker.

(4) Subject to subsection (5), if the worker makes an application under subsection (3), 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 subsection (2).

(5) The deductions made by the Board under subsection (4) may not be varied, except in response to an application by the worker to stop the deductions.

(6) A worker may only once

(a) make an application under subsection (3), and

(b) apply to stop the deductions

(7) An application made under subsection (3) or (5) must be in a form acceptable to the Board.

(8) The Board must provide each worker annually with a statement containing all relevant information about the funds accumulated by the Board for payment of the worker's retirement benefit.

Section 15:

A sum payable as compensation or by way of commutation of a periodic payment in respect of it is not capable of being assigned, charged or attached, nor must it pass by operation of law except to a personal representative, and a claim must not be set off against it, except for money advanced by way of financial or other social welfare assistance owing to the Province or to a municipality, or for money owing to the accident fund.

Section 34(2):

Subject to sections 7(4.1), 22(2) and 23(4), the Board must deduct, from the amount of a periodic payment of compensation paid to a worker under section 22(1) or 23(1) or (3) for an injury, an amount equal to 50% of any disability benefit that the worker is paid in respect of the injury under the *Canada Pension Plan*.

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 his or her retirement benefit.

Commencing the effective date of a permanent disability award, 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 15 of the *Act*.

The amounts set aside by the Board are deposited in a reserve in the Accident Fund.

However, where a worker's permanent disability award is totally or partially commuted, the future amounts to be set aside by the Board will also be totally or partially commuted. Please refer to policy items #45.00 to #45.61 in Chapter 6, Permanent Disability Awards 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 his or her permanent disability periodic payments to the amount set aside by the Board.

As part of the notification of a worker's entitlement to a permanent disability award, 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 15 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 Awards

Permanent disability awards under sections 22(1), 23(1) and 23(3) of the *Act* may be granted retroactively to a worker. The Board will set aside an amount equivalent to 5% of the retroactive award 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 award 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 policy item #50.00, Interest.

(4) Annual Statement

Under section 23.2(8), 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 15 and policy items #48.00 to #48.50 only when the retirement benefit is payable.

PRACTICE

Any Practice Directives developed for this POLICY and subsequent policies are available on the Board's Website, under the topic of *Rehabilitation Services & Claims Manual*.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	s.23.2, *Workers Compensation Act*
CROSS REFERENCES:	Chapter 6, Permanent Disability Awards
HISTORY:	Prior to June 30, 2002, permanent total disability awards (section 22(1)) and permanent partial disability awards assessed under the loss of function method of permanent disability assessment (section 23(1)) were payable for the lifetime of the worker. The duration of permanent partial disability benefits assessed under the projected loss of earnings method (section 23(3)) was addressed in 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 **ITEM: C18-116.10**
Payment of Retirement Benefits

BACKGROUND

1. Explanatory Notes

The *Act* defines "retirement benefit" as a lump sum payable under section 23.3.

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 his or her last monthly periodic payment, if after age 65.

Section 23.3(3) 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 23.3:

(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 23.2(2),

(b) the contributions, if any, made by the worker under section 23.2(4), 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), on the date the worker reaches 65 years of age, or

(b) on the date of the last periodic payment to the worker, if that date is after the date the worker reaches 65 years of age.

(3) Despite section 35(4), if a worker dies before receiving his or her retirement benefit under subsection (1), the Board must pay the lump sum to which the worker is 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 35(2)(a):

The Board may in its discretion

(a) commute all or part of the future amounts that are to be set aside for the payment of a retirement benefit and the periodic payments due or payable to the worker to one or more lump sum payments, to be applied as directed by the Board, and . . .

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 award 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 his or her permanent disability award, the *Act* provides that the amounts to be set aside by the Board will also be commuted.

Policy items #45.00 to #45.61 in Chapter 6, Permanent Disability Awards, which are used to determine a worker's eligibility to a permanent disability award commutation, are 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 his or her 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 award 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 award outlined above will be paid to a worker's estate if the worker dies prior to receiving the retirement benefit.

PRACTICE

Any Practice Directives developed for this POLICY and subsequent policies are available on the Board's Website, under the topic of *Rehabilitation Services & Claims Manual*.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	s.23.3, *Workers Compensation Act*
CROSS REFERENCES:	
HISTORY:	
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 23.4 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 39(1)(f) to enable the Board to assess employers to cover the cost of the retirement benefit.

Section 67 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 23.4:

(1) The Board must establish a reserve in the accident fund into which the amounts and contributions referred to in section 23.2(2) and (4) must be deposited.

(2) The funds deposited in the reserve 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 23.3.

(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 provisions of this part as if it were the Board.

Subsection 39(1)(f):

> (1) For the purpose of creating and maintaining an adequate accident fund the Board must every year assess and levy on and collect from independent operators and employers in each class, by assessment rated on the payroll, or by assessment rated on a unit of production, or in a manner the Board considers proper, sufficient funds, according to an estimate to be made by the Board …
>
> (f) provide and maintain a reserve for payment of retirement benefits.

Section 67(2):

> Subject to the supervision and direction of the Minister of Finance, the Board must cause all money in the accident and silicosis funds in excess of current requirements to be invested and reinvested and in doing so 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.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	June 30, 2002
AUTHORITY:	s.23.4, *Workers Compensation Act*
CROSS REFERENCES:	s.39(1)(f) and s.67(2) of the *Workers Compensation Act*
HISTORY:	Finance Division investment policy
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 **ITEM: C18-116.30**
Retirement Services and Personal Supports

BACKGROUND

1. Explanatory Notes

Section 23.5 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 23.5:

(1) If a worker has a permanent total disability, the Board must assess, within the 3-month period before the retirement benefit is payable to the worker, the need or continued need of the worker for services and personal supports under sections 16 and 21.

(2) After the assessment under subsection (1) is completed, the Board must take all actions necessary to provide to the worker, for his or her life, the services and personal supports under sections 16 and 21 that the Board considers are 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 sections 16 and 21.

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 award under section 22(1) of the *Act*, for rehabilitation, health care services 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.

(a) Rehabilitation and Health Care Services and Personal Supports

In assessing a worker, the Board will focus on those rehabilitation, 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 persons other than physicians or qualified practitioners (Item C10-77.00);
- health care facilities (Item C10-78.00);
- drugs, appliances and other supplies (Items C10-79.00 and C10-80.00);
- home and vehicle modifications (Item C10-81.00);
- clothing allowances (Item C10-82.00);
- personal care expenses and allowances (Item C10-84.00);
- independence and home maintenance allowances (Item C10-84.00);
- transportation allowances (Item C10-83.00);
- subsistence allowances (Item C10-83.10); or
- rehabilitation assistance (Chapter 11).

The services and supports listed above may be provided after age 65 where they are required due to the worker's permanent total disability.

(b) Excluded Rehabilitation and Health Care Services and Personal Supports

As the assessment is focussed on those services and supports a worker will need after retirement, the Board will not consider a worker's entitlement to services and assistance such as:

- vocational rehabilitation programs and services to assist in a worker's return to work efforts (policy items #88.00 to #88.60);
- vocational rehabilitation wage-loss equivalency benefits (policy item #89.11); or
- income loss benefits provided as a health care benefit (Item C10-83.10).

This list is not exhaustive and the Board may alter this list as required.

(c) Reviews After Retirement

The Board may at its discretion, periodically review a worker's need or continued need for services and supports following the worker's retirement. Based on these reviews, the Board may confirm, adjust or discontinue the provision of these supports and services. For example, a change in the worker's compensable medical status may require the Board to modify the amount and type of services or supports needed by the worker.

PRACTICE

For any relevant PRACTICE information, readers should consult the Practice Directives available on the WorkSafeBC website.

EFFECTIVE DATE:	June 1, 2009 – Delete references to Vocational Rehabilitation Services.
AUTHORITY:	s. 23.5, *Workers Compensation Act*
CROSS REFERENCES:	See also Establishment of Amounts Set Aside and Contributed (policy item #116.00), Chapter 6 - Permanent Disability Awards, Chapter 10 – Health Care.

HISTORY: Consequential amendments arising from changes to Chapter 10, *Medical Assistance, Rehabilitation Services and Claims Manual,* were made effective January 1, 2015.
June 30, 2002 - New policy that sets out how the Board will comply with section 23.5 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

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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
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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

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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
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253	Replacement of Eyeglasses and Wage Loss	June 17, 2003
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261	Temporary Partial Disability	June 17, 2003
262	Disability and Unemployability	June 17, 2003
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264	Compensation Payable when Company Unregistered	May 1, 2000
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266	Adjustments According to the Consumer Price Index	May 1, 2000

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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
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297	Dual System and Non-Spinal Injuries	May 1, 2000
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307	The Fishing Industry	January 1, 2003
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343	Scope of Employment	June 1, 2004
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347	Oral Hearings on Appeals to the Commissioners	May 1, 2000
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349	Industrial Health and Safety Regulations	October 21, 2003
350	Commissioners' Decisions	May 1, 2000

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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

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373	Adjustments According to the Consumer Price Index	May 1, 2000
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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

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394	The Dual System of Measuring Disability	October 21, 2003
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398	The Consumer Price Index	May 1, 2000
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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 B – #26.01

SECTION 6(4)

DESCRIPTION OF DISEASE	DESCRIPTION OF PROCESS OR INDUSTRY
1. Poisoning by:	
(a) Lead	Where there is an exposure to lead or lead compounds.
(b) Mercury	Where there is an exposure to mercury or mercury compounds.
(c) Arsenic or arsine	Where there is an exposure to arsenic or arsenic compounds.
(d) Cadmium	Where there is an exposure to cadmium or cadmium compounds.
(e) Manganese	Where there is an exposure to manganese or manganese compounds.
(f) Phosphorus, phosphine or due to the anti-cholinesterase action of organic phosphorus compounds.	Where there is an exposure to phosphorus or phosphorus compounds.
(g) Organic solvents (n-hexane, carbon tetrachloride, trichloroethane, trichloro-ethylene, acetone, benzene, toluene, xylene and others)	Where there is exposure to organic solvents.

(h) Carbon monoxide	Where there is exposure to products of combustion, or any other source of carbon monoxide.
(i) Hydrogen sulphide	Where there is excessive exposure to hydrogen sulphide.
(j) Nitrous fumes (including silo-filler's disease)	Where there is excessive exposure to nitrous fumes including the oxides of nitrogen.
(k) Nitriles, hydrogen cyanide or its soluble salts	Where there is exposure to chemicals containing -CN group including certain pesticides.
(l) Phosgene	Where there is excessive exposure to phosgene including its occurrence as a breakdown product of chlorinated compounds by combustion.
(m) Other toxic substances	Where there is exposure to such toxic gases, vapours, mists, fumes or dusts.

2. Infection caused by:

(a) Psittacosis virus	Where there is established contact with ornithosis-infected avian species or material.
(b) Staphylococcus aureus, Salmonella organisms, Hepatitis B virus	Employment where close and frequent contact with a source or sources of the infection has been established and the employment necessitates: (1) the treatment, nursing or examination of or interviews with patients or ill persons; or (2) the analysis or testing of body tissues or fluids; or (3) research into salmonellae, pathogenic staphylococci or Hepatitis B virus.

(c) Brucella organisms (Undulant fever)	Where there is contact with animals, carcasses or animal by-products.
(d) Tubercle bacillus	Employment where close and frequent contact with a source or sources of tuberculous infection has been established and the employment necessitates: (1) the treatment, nursing or examination of patients or ill persons: or (2) the analysis or testing of body tissues or fluids; or (3) 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 primary tuberculosis as proven by a negative tuberculin test at time of employment). In the case of an employee previously compensated for tuberculosis, any subsequent tuberculosis after the disease has become inactive and has remained inactive for a period of three years or more shall not be deemed to have occurred as a result of the original disability

		for the purpose of the Act, 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:	
	(a) Silicosis	Where there is exposure to airborne silica dust including metalliferous mining and coal mining.
	(b) Asbestosis	Where there is exposure to airborne asbestos dust.
	(c) 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.
3A.	Diffuse pleural thickening or fibrosis, whether unilateral or bilateral	Where there is exposure to airborne asbestos dust and the worker has not previously suffered and is not currently suffering collagen disease, chronic uremia, drug-induced fibrosis, tuberculosis or other infection, trauma, or disease capable of causing pleural thickening or fibrosis.
3B.	Benign pleural effusion, whether unilateral or bilateral	Where there is exposure to airborne asbestos dust and the worker has not previously suffered and is not currently suffering collagen disease, chronic uremia, tuberculosis or other infection, trauma, or disease capable of causing pleural effusion.

4. Cancer:

(a.1) Primary carcinoma of the lung when associated with:	
(i) asbestosis	Where there is exposure to airborne asbestos dust.
or	
(ii) bilateral diffuse pleural thickening over 2 mm thick	Where there is exposure to airborne asbestos dust and the worker has not previously suffered collagen disease, chronic uremia, drug-induced fibrosis, tuberculosis or other infection or trauma capable of causing pleural thickening.
(a.2) 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: (1) asbestos mining; (2) insulation or filter material production; (3) construction (where there is disturbance of asbestos-containing materials); (4) plumbing or electrical work; (5) pulp mill work; (6) shipyard work; (7) longshoring.
(b) Mesothelioma (pleural or peritoneal)	Where there is exposure to airborne asbestos dust.
(c) Carcinoma of the larynx or pharynx associated with asbestosis	Where there is exposure to airborne asbestos dust.

(d)	Gastro-intestinal cancer including all primary cancers associated with the oesophagus, stomach, small bowel, colon and rectum excluding the anus, and without regard to the site of the cancer in the gastro-intestinal 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 gastro-intestinal 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 occupational activity in which it occurred.
(e)	Primary cancer of the lung	Where there is prolonged exposure to: (1) aerosols and gases containing arsenic, chromium, nickel or their compounds; or (2) bis (chloromethyl) ether; or (3) the dust of uranium, or radon gas and its decay products; or (4) particulate polycyclic aromatic hydrocarbons.
(f)	Leukemia or pre-leukemia	Where there is prolonged exposure to benzene or to ionizing radiation.
(g)	Primary cancer of the skin	Where there is prolonged contact with coal tar products, arsenic or cutting oils or prolonged exposure to solar ultra-violet light.
(h)	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.
(i)	Primary cancer of the mucous lining of the nose or nasal sinuses	Where there is prolonged exposure to dusts, fumes or mists containing nickel or the dusts of hard woods.
(j)	Angiosarcoma of the liver	Where there is exposure to vinyl chloride monomer.

5.	Repealed (BC Reg 188/2000)	
6.	Asthma	Where there is exposure to: (1) western red cedar dust; or (2) isocyanate vapours or gases; or (3) the dusts, fumes or vapours of other chemicals or organic material known to cause asthma.
7.	Extrinsic allergic alveolitis (including farmers' lung and mushroom workers' lung)	Where there is repeated exposure to respirable organic dusts.
8.	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 there is exposure to a high concentration of fumes, vapours, gases, mists, or dust of substances that have irritating or inflammatory properties, and the respiratory symptoms occur within 48 hours of the exposure, or within 72 hours where there is exposure to nitrogen dioxide or phosgene.
9.	Metal fume fever	Where there is exposure to the fume of zinc or other metals.
10.	Fluorosis	Where there is exposure to high concentrations of fluorine or fluorine compounds in gaseous or particulate form.
11.	Neurosensory hearing loss	Where there is prolonged exposure to excessive noise levels.

12.	Bursitis:	
	(a) Knee bursitis (inflammation of the prepatellar, suprapatellar, or superficial infrapatellar bursa)	Where there is repeated jarring impact against, or where there are significant periods of kneeling on, the involved bursa.
	(b) 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 60 degrees and where such activity represents a significant component of the employment.
13.	Tendinopathy:	
	(a) Hand-wrist tendinopathy	Where there is use of the affected tendon(s) to perform a task or series of tasks that involves any two of the following: (1) frequently repeated motions or muscle contractions that place strain on the affected tendon(s); (2) significant flexion, extension, ulnar deviation or radial deviation of the affected hand or wrist; (3) forceful exertion of the muscles utilized in handling or moving tools or other objects with the affected hand or wrist; and where such activity represents a significant component of the employment.
	(b) Shoulder tendinopathy	Where there is frequently repeated or sustained abduction or flexion of the shoulder joint greater than 60 degrees and where such activity represents a significant component of the employment.

14.	Decompression sickness	Where there is exposure to increased air pressure.
15.	Contact dermatitis	Where there is excessive exposure to irritants, allergens or sensitizers ordinarily causative of dermatitis.
16.	Hand-arm vibration syndrome	Where there have been at least 1000 hours of exposure to tools or equipment which cause the transfer of significant vibration to the hand or arm of the worker.
17.	Radiation injury or disease:	
	(a) Due to ionizing radiation	Where there is exposure to ionizing radiation.
	(b) Due to non-ionizing radiation:	
	(i) conjunctivitis, keratitis	Where there is exposure to ultra-violet light.
	(ii) cataract or other thermal damage to the eye.	Where there is excessive exposure to infra-red, microwave or laser radiation.
18.	Erosion of incisor teeth	Where there is exposure to acid fumes or mist.

APPENDIX 3

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APPENDIX 4

PERMANENT DISABILITY EVALUATION SCHEDULE

Rehabilitation Services & Claims Manual
Volume II

WORKSAFEBC
WORKING TO MAKE A DIFFERENCE

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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 23(2) of the *Act*, the Schedule is used for guidance in the measurement of partial disability under section 23(1) 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 an award under section 23(1) 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 23(1) award. 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 policy item #39.10, *Permanent Disability Evaluation Schedule*).

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:

> Award 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 disability award 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 awarded. This is known as the "enhancement factor".

Enhancement is only applied to scheduled awards. An enhancement factor is not applied to non-scheduled awards, such as 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 awarded 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 awarded 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 awarded 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 awarded is 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 D/Section 7 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. Upper Extremities; 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 a disability award.

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.

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 is in the upper extremity is assessed as follows:

Loss of strength	Definition	Percentage
Normal	No loss of function	0
Mild	Active movement against strong resistance	1
Moderate	Active movement against slight resistance	3
Marked	Movement against gravity	5
Complete	No power	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

Biceps tendon rupture (with no surgical correction)

Proximal 1.5
Distal 2

If surgical repair of a biceps tendon rupture is undertaken, disability is rated based on loss of range of motion and loss of strength resulting from the accepted injury and surgical repair, and not the above values. The above ratings for biceps tendon rupture with no surgical correction include consideration of associated loss of range of motion and loss of strength.

Acromioclavicular (AC) or lateral clavicular joint resection..... 3

Distal clavicular 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 awarded in respect of an amputation of the thumb or a single finger.

Hand charts 3 to 5 set out the percentages of disability awarded 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 an award is granted 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 award 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:

$$\left(\frac{1}{3}\left(\frac{pinch\ grip\ loss\ of\ strength}{normal\ pinch\ grip\ strength}\right) + \left(\frac{hand\ grip\ loss\ of\ strength}{normal\ hand\ grip\ strength}\right)\right) \times 100 = total\ percentage\ loss\ of\ strength$$

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

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. Pinch grip technique employs lateral or "key" pinch grip.
5. The highest hand or 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 <u>both</u> 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, an award of up to the full amputation value of the most distal remaining phalanx may be granted**.**

F. Cold Intolerance

Where a worker has been diagnosed with cold intolerance which is associated with a compensable hand injury, a disability award for cold intolerance may be granted. Disability from cold intolerance is calculated as 50% of the total disability 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.

V. Hands

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 awarded in respect of an amputation of the thumb or a single finger.

Charts 3 to 5 set out the percentages of disability awarded 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.

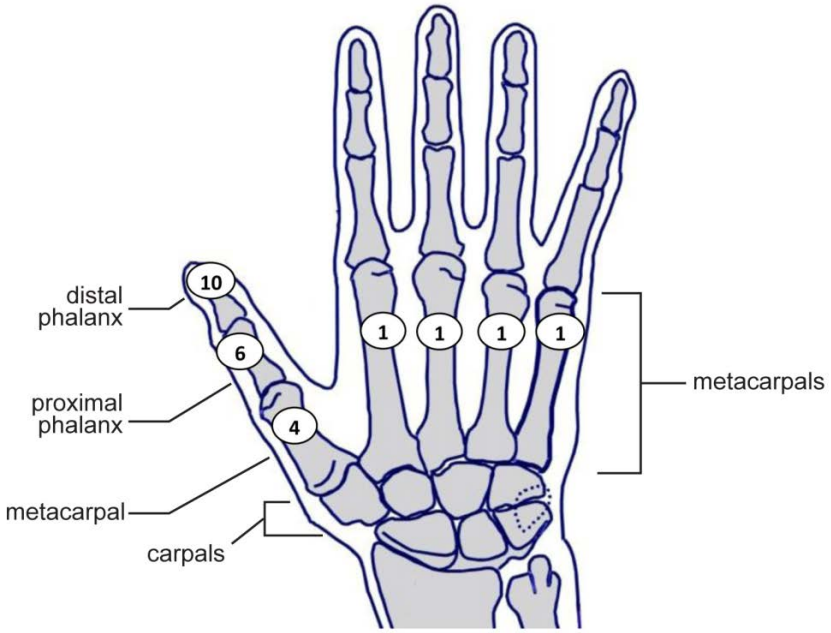

CHART 1: Thumb and Metacarpals

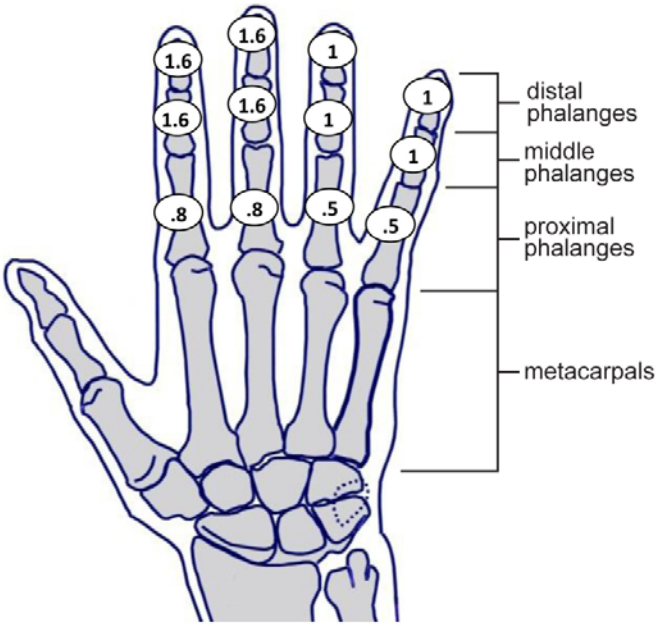

CHART 2: Single Finger

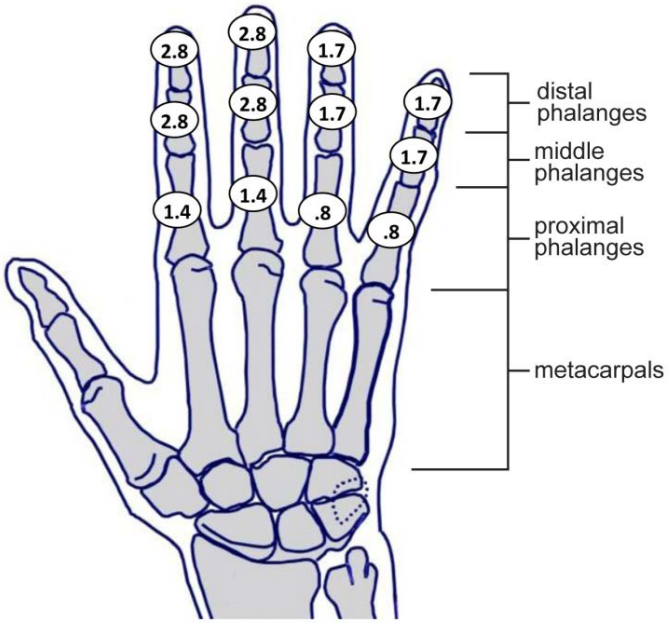

CHART 3: Two Fingers

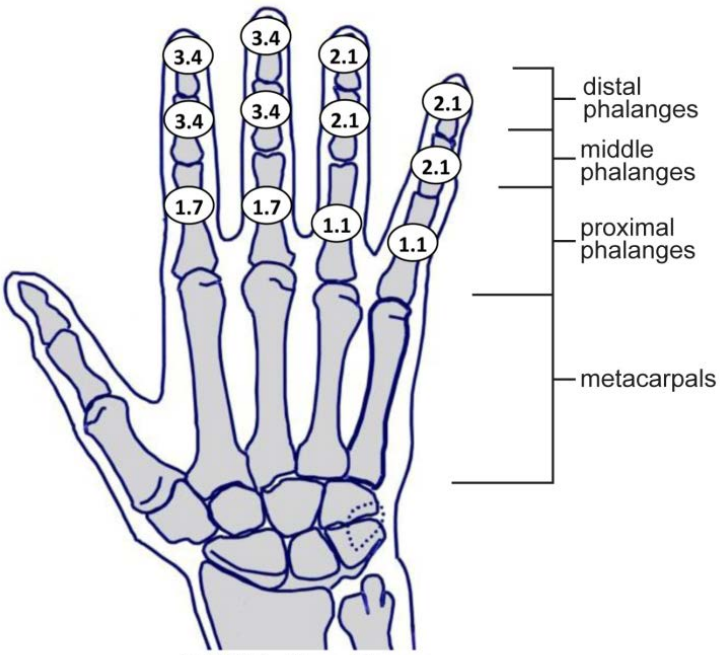

CHART 4: Three Fingers

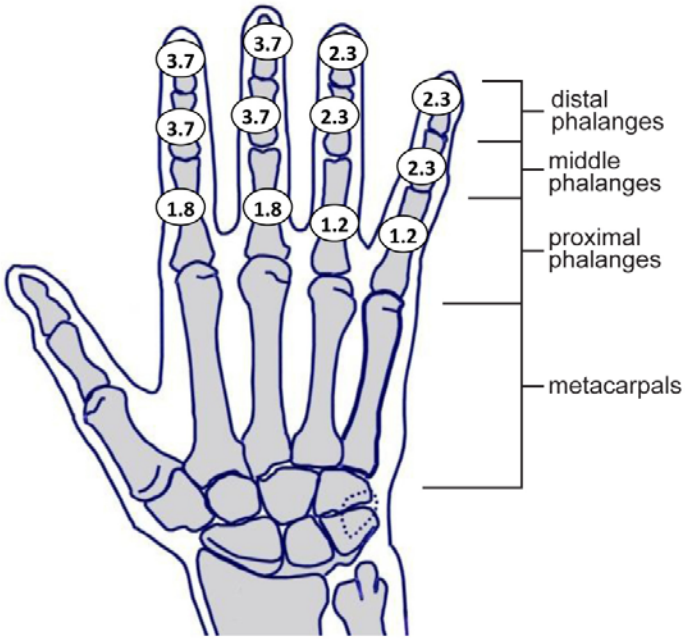

CHART 5: Four Fingers

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 awarded. That percentage is then added to any percentage of disability awarded 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

Disability from 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

Disability from 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.

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 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:

Strength Loss	Definition	Percentage
Normal	No loss of function	0
Mild	Active movement against strong resistance	1
Moderate	Active movement against slight resistance	3
Marked	Movement against gravity	5
Complete	No power	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 award for valgus and/or varus angulation of the knee may be added to the award 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 granted 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.

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..... 0 – 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, immobility of joints, 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 awarded.

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

Normal	No loss of function
Mild	Active movement against strong resistance
Moderate	Active movement against slight resistance
Marked	Movement against gravity
Complete	No power

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 Awards for Peripheral Nerve Conditions

(Values listed in this table are percentages of total disability)

		Sensory	Motor
Long Thoracic Nerve			
	Normal	n/a	0
	Mild	n/a	2
	Moderate	n/a	3
	Marked	n/a	4
	Complete	n/a	5
Median Nerve			
At elbow	Normal	0	0
	Mild	5	5
	Moderate	10	10
	Marked	15	15
	Complete	20	20
At wrist	Normal	0	0
	Mild	3	2
	Moderate	6	4
	Marked	9	6
	Complete	12	8
Ulnar Nerve			
At elbow	Normal	0	0
	Mild	0.75	3
	Moderate	1.5	6
	Marked	2.25	10
	Complete	3	16
At wrist	Normal	0	0
	Mild	0.6	2
	Moderate	1.2	4
	Marked	1.8	8
	Complete	2.4	10
Radial Nerve			
	Normal	0	0
	Mild	0.5	4.5
	Moderate	1	9
	Marked	1.5	13.5
	Complete	2	18

		Sensory	Motor
Axillary Nerve			
	Normal	0	0
	Mild	0.15	1.35
	Moderate	0.3	2.7
	Marked	0.45	4.05
	Complete	0.6	5.4
Lateral Cutaneous Nerve of the Forearm			
	Normal	0	n/a
	Mild	0.5	n/a
	Moderate	1	n/a
	Marked	1.5	n/a
	Complete	2	n/a
Medial Cutaneous Nerve of the Forearm			
	Normal	0	n/a
	Mild	0.5	n/a
	Moderate	1	n/a
	Marked	1.5	n/a
	Complete	2	n/a
Musculocutaneous Nerve of the Brachial Plexus			
	Normal	0	0
	Mild	.5	4.5
	Moderate	1	9
	Marked	1.5	13.5
	Complete	2	18
Sciatic Nerve			
	Normal	0	0
	Mild	3	4.5
	Moderate	6	9
	Marked	9	13.5
	Complete	12	18
Femoral Nerve			
	Normal	0	0
	Mild	0.625	2.5
	Moderate	1.25	5
	Marked	1.875	7.5
	Complete	2.5	10

		Sensory	Motor
Obturator Nerve			
	Normal	0	0
	Mild	0.625	2.5
	Moderate	1.25	5
	Marked	1.875	7.5
	Complete	2.5	10
Saphenous Nerve			
	Normal	0	n/a
	Mild	1	n/a
	Moderate	2	n/a
	Marked	3	n/a
	Complete	4	n/a
Common Peroneal Nerve (Lateral Popliteal)			
	Normal	0	0
	Mild	1	5
	Moderate	2	10
	Marked	3	15
	Complete	4	20
Deep Peroneal Nerve (Anterior Tibial)			
	Normal	0	0
	Mild	0.2	2.5
	Moderate	0.3	5
	Marked	0.4	10
	Complete	0.5	15
Superficial Peroneal Nerve (Musculocutaneous)			
	Normal	0	0
	Mild	0.4	0.5
	Moderate	0.6	1
	Marked	0.8	2
	Complete	1	2.5
Tibial Nerve (Posterior Tibial or Medial Popliteal)			
	Normal	0	0
	Mild	2	3
	Moderate	4	6
	Marked	6	9
	Complete	8	12

		Sensory	Motor
Sural Nerve			
	Normal	0	n/a
	Mild	0.5	n/a
	Moderate	1	n/a
	Marked	1.5	n/a
	Complete	2.0	n/a
Lateral Femoral Cutaneous Nerve (Lateral Cutaneous Nerve of the Thigh)			
	Normal	0	n/a
	Mild	0.5	n/a
	Moderate	1	n/a
	Marked	1.5	n/a
	Complete	2.0	n/a
Posterior Cutaneous Nerve of the Thigh			
	Normal	0	n/a
	Mild	0.5	n/a
	Moderate	1.0	n/a
	Marked	1.5	n/a
	Complete	2.0	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

Normal	No loss of function
Mild	Active movement against strong resistance
Moderate	Active movement against slight resistance
Marked	Movement against gravity
Complete	No power

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.

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 Awards 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.

Nerve Root		Sensory	Motor
C5	Normal	0	0
	Mild	1	4
	Moderate	2	8
	Marked	3	12
	Complete	4	16
C6			
	Normal	0	0
	Mild	1.5	4.5
	Moderate	3	9
	Marked	4.5	13.5
	Complete	6	18
C7	Normal	0	0
	Mild	1	5
	Moderate	2	10
	Marked	3	15
	Complete	4	20
C8	Normal	0	0
	Mild	1	6
	Moderate	2	12
	Marked	3	18
	Complete	4	24
T1	Normal	0	0
	Mild	0.5	3
	Moderate	1	6
	Marked	1.5	10
	Complete	2	14

IX. Nerve Root Conditions

		Sensory	Motor
T2	Normal	0	n/a
	Mild	0.5	n/a
	Moderate	1	n/a
	Marked	1.5	n/a
	Complete	2	n/a
T3 through T12	Normal	0	n/a
	Mild	0.125	n/a
	Moderate	0.25	n/a
	Marked	0.375	n/a
	Complete	0.5	n/a
L1	Normal	0	0
	Mild	1	3
	Moderate	2	6
	Marked	3	9
	Complete	4	12
L2	Normal	0	0
	Mild	1	3
	Moderate	2	6
	Marked	3	9
	Complete	4	12
L3	Normal	0	0
	Mild	1	3
	Moderate	2	6
	Marked	3	9
	Complete	4	12
L4	Normal	0	0
	Mild	1	3
	Moderate	2	6
	Marked	3	9
	Complete	4	12
L5	Normal	0	0
	Mild	1	5
	Moderate	2	10
	Marked	3	15
	Complete	4	20

		Sensory	Motor
S1	Normal	0	0
	Mild	1.5	3
	Moderate	3	6
	Marked	4.5	9
	Complete	6	12
S2 through S5*	Normal	0	0
	Mild	0.5	2
	Moderate	1	4
	Marked	1.5	6
	Complete	2	8

*any related award for urological or sexual dysfunction would be added to the sensory loss award.

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 an award equivalent to the rating for a two-level fusion, plus the rating for total collapse of the removed vertebra.

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 D/Section 7 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 award for urological or sexual dysfunction would be added to the sensory loss award 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

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, immobility of joints, 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

This table 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.

G. Impairments of the Upper Extremities

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% of total disability 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	12.25	14.5	15.5	16.5	18.5	22.5	26.5	26.5
60	4	4	9.25	14.5	16	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	83
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	83	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. Photosensitivity/Photophobia

Percentage

Mild photosensitivity is eliminated by sunglasses and/or a hat 0

Moderate photosensitivity is present when the symptoms are not completely relieved with sunglasses or a sun shade but the individual is able to perform the activities of daily living and work ..... 1 – 3

Severe photosensitivity is present when the individual is unable to drive (day or night) or to venture into daylight without severe discomfort..... 4 – 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, disability ratings for secondary ocular conditions may be added to any applicable disability 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.

Percentage

Complete loss of hearing in one ear with no loss in the other..... 3

Complete loss of hearing in both ears..... 30

A. Unilateral Traumatic Hearing Loss

Difference in loss of hearing in decibels (dB) measured in affected ear (ANSI)	Percentage
20 – 29	1
30 – 39	2
40 or more	3

The loss of hearing 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 audiometry at frequencies of 500, 1,000, 2,000 and 3,000 Hz.

B. Bilateral Traumatic Hearing Loss

Loss of hearing in decibels (dB) measured in each ear in turn (ANSI)	Percentage		
	ear most affected	PLUS	ear least affected
35 – 39	0.2		1.8
40 – 44	0.3		2.7
45 – 49	0.5		4.5
50 – 54	0.7		6.3
55 – 59	1.0		9.0
60 – 64	1.3		11.7
65 – 69	1.7		15.3
70 – 74	2.1		18.9
75 – 79	2.6		23.4
80 or more	3.0		27.0

The loss of hearing 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 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). This is done for each ear.

XIV. Non-Traumatic Hearing Loss
(Schedule D/Section 7 of the *Act*)

Percentage

Complete loss of hearing in one ear with no loss in the other..... 3

Complete loss of hearing in both ears..... 15

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

The loss of hearing in decibels in the first column is the arithmetic average of thresholds of hearing measured in each ear in turn by pure tone, air conduction audiometry at frequencies of 500, 1,000 and 2,000 Hz.

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 awarded 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 meter 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

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.[1]

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	< 120 and	< 130 and	130 - 139 or	140 - 159 or	160 - 179 or	≥ 180 or
Diastolic	< 80	< 85	85 - 89	90 - 99	100 - 109	≥ 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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Courtesy Statistical Bulletin, Metropolitan Life Insurance Company.

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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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

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 awards 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.

	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 zero percent.

   (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 Maneuvers", "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":

number of years of smoking	x	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 Maneuvers (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 claimant, 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 claimant 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 claimant's complaint of dyspnea is due to respiratory or cardiac conditions.

- Exercise capacity is measured by oxygen consumption per unit time in milliliters per kilogram multiplied by minutes, or in metabolic equivalents (METS).

- Generally, an individual can sustain a work level equal to 40% of his/her 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 claimants 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 claimant is at rest, breathing room air at sea level.

- Arterial PO_2 less than 60 mm Hg may also indicate severe impairment if the claimant 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 claimants being assessed for respiratory impairment require spirometry.

- Claimant 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

Signs and Symptoms	Treatment (see below for details)	Percentage
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 he or she 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
Skin disorder signs and symptoms present or intermittently present.	Requires no or intermittent treatment with agents listed in 1 below.	3 – 5
Skin disorder signs and symptoms intermittently or constantly present.	Requires intermittent treatment with agents listed in 1 and 2 below.	6 – 24
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 officer may consider the limitations experienced by the worker in his or her activities of daily living.

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 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

APPENDIX B

Pulmonary Function Table I

Predicted Normal Forced Vital Capacity (FVC) in Liters 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 liters = 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 vapor 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 liters. 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 Liters 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 liters = 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 vapor 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 liters. 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 Liters 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 liters = 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 vapor 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 liters. 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 Liters 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 liters = 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 vapor 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 liters. 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 vapor). 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 vapor). 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

APPENDIX C

EFFECTIVE DATE:	May 1, 2017
AUTHORITY:	Sections 23(1) and 23(2) of the *Act*
CROSS REFERENCES:	Policy item #39.10, *Permanent Disability Evaluation Schedule*
HISTORY:	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 of the Permanent Disability Evaluation Schedule. 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–revisions to the Permanent Disability Evaluation Schedule to consolidate and incorporate 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. Revisions also to consolidate and incorporate 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 January 1, 2019.

APPENDIX 5

FORMULAE FOR RECALCULATING PENSIONS UNDER SECTION 24 – POLICY ITEM #46.02

A. Calculation for Workers Under 65

(a) Deemed current pension (the monthly pension being paid on the date of adjustment, plus any periodical payments that have been commuted or the life equivalent of any periodical payments made for a fixed term). 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 pension, i.e., (i) – (a). _____ j) (if negative, enter zero)

(k) Statutory maximum (maximum earnings applicable under section 33 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 awarded at the date of the adjustment to a worker suffering the same disability as the applicant worker. _____ m)

(n) Maximum adjusted pension applicable on this claim (l) x (m). _____ n)

(o) Adjusted monthly pension = lesser of (n) or (i). _____ o)

(p) Actual adjustment. Pension increased by (o) – (a).

The new rate of pension 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 pension (the monthly pension being paid on the date of the adjustment, plus any periodical payments that have been commuted or the life equivalent of any periodical payments made for a fixed term. 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 pension, i.e., (h) – (c). _____ i) (if negative, enter zero)

(j) Statutory maximum (maximum earnings applicable under section 33 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 awarded at the date of the adjustment to a worker suffering the same disability as the applicant worker.

_____ l)

(m) Maximum adjusted pension applicable on the claim, i.e., (l) x (k). _____ m)

(n) Adjusted monthly pension, i.e., lesser of (m) or (h). _____ n)

(o) Actual adjustment, pension 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 disability pension payments to age 65 = deemed current pension (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 awarded at the date of the adjustment for the disability sustained by the applicant. %_____1)

(2) Monthly allowance 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.

Effective June 30, 2002, the percentage change in the Consumer Price Index determined under section 25.2 of the *Act*, as described in policy item #51.20, will be used.

Rates

January 1, 2018	–	$3.57 for each 1%
January 1, 2019	–	$3.66 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.

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 PENSION

(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 pension (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 6

MAXIMUM FINES FOR COMMITTING OFFENCES UNDER THE *ACT*

Section 77(2) provides that “Every person who commits an offence under this Part for which no other punishment has been provided is liable on conviction to a fine not exceeding. . .” the amount set out below.

Date			Amount
January 1, 2018	–	December 31, 2018	$5,412.08
January 1, 2019	–	December 31, 2019	$5,544.38

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

APPENDIX 7

This Appendix Has Been Deleted

Note: This reference index, which is the same index as found in Volume I, has not yet been updated for Volume II. This index is provided at this time, for your convenience, as many of the references will remain the same once an update is completed.

REHABILITATION SERVICES AND CLAIMS MANUAL REFERENCE INDEX

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"X" IN LIEU OF A SIGNATURE ON AN APPLICATION FOR COMPENSATION 93.25

X-RAYS RE CHIROPRACTORS 74.27

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YOUTH AS A CRITERIA FOR RATE SETTING ACT 33(3), 67.10

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