2020/07/22-02

WORKERS' COMPENSATION BOARD

RESOLUTION OF THE BOARD OF DIRECTORS

RE: Substantive Changes to Policy in the *Rehabilitation Services & Claims Manual,* Volume II Consequential to Implementing the Revised *Workers Compensation Act*

WHERERAS:

Pursuant to the *Statute Revision Act*, R.S.B.C. 1996, c. 440, the British Columbia Office of Legislative Counsel revised the *Workers Compensation Act*, R.S.B.C. 1996, c. 492, which came into force on April 6, 2020, as the *Workers Compensation Act*, R.S.B.C. 2019, c. 1 (*Act*);

WHEREAS:

Pursuant to section 319 of the *Act*, the Board of Directors of the Workers' Compensation Board (WorkSafeBC) must set and revise as necessary the policies of the Board of Directors, including policies respecting occupational health and safety, compensation, rehabilitation, and assessment;

AND WHEREAS:

Pursuant to Resolution 2020/03/25-03, to reflect the statutory revisions, the Board of Directors approved consequential changes to policies in the *Rehabilitation Services & Claims Manual*, Volume II (*RS&CM*, Vol. II);

AND WHEREAS:

In the course of reviewing the policies for the purpose of the statutory revisions, four policies in the *RS&CM*, Vol. II were identified as requiring minor substantive changes not related to the statutory revisions;

AND WHEREAS:

In the course of reviewing the schedule used for guidance in the measurement of permanent partial disability for the purposes of section 195(3) of the *Act* – the *Permanent Disability Evaluation Schedule* (*PDES*) found in Appendix 3 of the *RS&CM*, Vol. II – for the purpose of the statutory revisions, an error was found in the *PDES*;

AND WHEREAS:

WorkSafeBC's Policy, Regulation and Research Division has undertaken stakeholder consultation on this issue and has advised the Board of Directors on the results of the consultation;

THE BOARD OF DIRECTORS RESOLVES THAT:

1. The amendments to the following policies in the *RS&CM*, Vol. II, as set out in Appendix 1 attached to this resolution, are approved, and apply to all decisions made on or after September 1, 2020:

   Policy item #41.00, *Duration of Permanent Disability Periodic Payments*

   Policy item #48.22, *Social Assistance Payments*

   Policy item #69.11, *Permanent Disability Lump Sum Compensation and Permanent Disability Compensation for a Fixed Term*

   Policy item #114.40, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*.

2. The amendments to the *PDES* attached as Appendix 3 to the *RS&CM*, Vol. II, as set out in Appendix 2 attached to this resolution, are approved, and apply to all decisions made on or after September 1, 2020.

3. This resolution is effective September 1, 2020.

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

I, Lee Loftus, hereby certify for and on behalf of the Board of Directors of WorkSafeBC that the above resolutions were duly passed at a meeting of the Board of Directors held in Richmond, British Columbia, on July 22, 2020.

LEE LOFTUS
Acting Chair, Board of Directors
Workers' Compensation Board

APPENDIX 1

POLICY

***Rehabilitation Services & Claims Manual*, Volume II**

Additions in Highlighted Bold. Deletions Struckthrough.

#41.00 DURATION OF PERMANENT DISABILITY PERIODIC PAYMENTS

Section 201(1) of the *Act* provides:

Subject to subsection (2), periodic payment of compensation under this Division [Division 6 of Part 4 of the *Act* – Compensation for Worker Disability] may be paid to an injured worker only as follows:

(a) if the worker is under 63 years of age on the date of the injury, until the later of the following:

(i) the date the worker reaches 65 years of age;

(ii) if the Board is satisfied the worker would retire after reaching 65 years of age, the date the worker would retire, as determined by the Board;

(b) if the worker is 63 years of age or older on the date of the injury, until the later of the following:

(i) 2 years after the date of the injury;

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

For the purpose of permanent disabilities, section 201(1) of the *Act* provides for the payment of permanent disability benefits until a worker reaches 65 years of age.

If the Board is satisfied a worker would retire after reaching 65 years of age, section 201(1) permits the Board to continue to pay permanent disability 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 the injury.

As age 65 is the established retirement age under the *Act*, to continue to pay benefits after the age of 65, the evidence must support a finding that the worker would work past age 65. Evidence is also required so that the Board can establish the worker's new retirement date for the purposes of concluding permanent disability benefits payments. The standard of proof under section 339(3) of the *Act* is "at least as likely as not" as described in policy item #97.00.

The issue for the Board to determine is whether it is "at least as likely as not" that the worker would have retired after age 65. The Board considers the worker's statement of intention to retire after age 65, but must determine whether it is "at least as likely as not" that the worker would actually have retired later than age 65.

Examples of the kinds of evidence that may support a finding that a worker would retire after reaching 65 years of age 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 the employer(s) 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 evidence in support of a determination that a worker would have worked until after age 65.

The following are examples of other kinds of evidence that alone may not support a finding that 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.

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

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 permanent disability benefits. For example, when a worker's retirement date impacts a worker's entitlement to wage-loss benefits or vocational rehabilitation benefits.

In these cases, the retirement date on the wage-loss benefits or vocational rehabilitation benefits will also apply to the resulting permanent disability benefits, if granted.

If the Board is satisfied that a worker would have continued to work past age 65 if the injury had not occurred, permanent disability 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 permanent disability periodic payments dies from causes unrelated to the disability, the periodic payments will continue for the full month in which the death occurred. The effect of this policy will be that no overpayments will be considered to have arisen for the period from the date of the worker's death up to the end of the month covered by the last periodic payment.

If the worker dies prior to the commencement of payments for the permanent disability benefits, the compensation is calculated and paid to the date of death. The situation where such a worker would have received the permanent disability benefit as a lump sum payment is dealt with in policy item #45.00.

EFFECTIVE DATE:	~~February 1, 2020~~**September 1, 2020**
AUTHORITY:	Section 201 of the *Act*.
CROSS REFERENCES:	Policy item #48.44, *Deduction of Overpayments from Permanent Disability Benefits*; Policy item #45.00, *Lump Sums and Commutations*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	**September 1, 2020 − Policy amended to clarify examples of evidence are parallel in policy item #41.00 and policy item #35.30 of the *Rehabilitation Services & Claims Manual,* Volume II.** April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2020 – Policy amended to provide guidance on legal issues of standard of proof, evidence, and causation.
APPLICATION:	Applies to all decisions made on or after ~~February 1, 2020~~**September 1, 2020**.

#48.22 Social Assistance Payments

Deductions from compensation may be made in respect of social assistance payments made to the worker by British Columbia.

When a person who may be entitled to compensation receives social assistance payments, British Columbia may require the person to execute an assignment to it of any benefits received from the Board. The assignment is then passed on to the Board to notify it to deduct from the worker's compensation benefits the amount owed to British Columbia.

The rules set out below are followed in respect of assignments of compensation made by a worker to British Columbia.

1. No overpayment of compensation is declared and sought to be recovered in respect of payments of compensation made prior to the receipt of an assignment of benefits made by a worker to British Columbia.

2. In respect of payments of compensation made after receipt of the assignment:

   (a) Wage-Loss Benefit Payments

   Refunds will only be made to British Columbia for wage-loss benefit periods which are concurrent with periods where assistance has been paid and only up to the amount of the assistance paid for that period.

   (b) Monthly Permanent Disability Benefit Payments

   British Columbia will be refunded up to the monthly value of the permanent disability payment for concurrent periods. This will usually apply only to retroactive payments. Ongoing assistance, if being paid, will be adjusted by British Columbia beyond the implementation date of the permanent disability benefits.

   (c) Permanent Disability Benefits: Lump Sum Cash Payments or Commutations

   If a lump sum is paid or a commutation is ~~granted~~**provided**, British Columbia will be reimbursed the equivalent amount of

the monthly permanent disability benefit that would otherwise have been payable to the worker. This will be for the same period of time covered by the assistance payment. This will only apply up to the amount of assistance paid by British Columbia for that period. **For lump-sum payments, t**~~T~~This will generally only occur where the lump sum ~~or commutation~~ is being paid on a retroactive basis.

(d) Rehabilitation Allowances

British Columbia has agreed not to request an Assignment of Benefits from rehabilitation allowances paid under section 155 of the *Act*.

3. Where no payments of compensation on the claim are due after receipt of the assignment or the payments cease before the full amount owed to British Columbia is paid off, British Columbia is advised that it will have to collect the amount outstanding through other means.

The worker is advised when social assistance payments are being deducted from workers' compensation benefits.

EFFECTIVE DATE:	~~February 1, 2020~~**September 1, 2020**
HISTORY:	**September 1, 2020 − Policy amended to address an inconsistency with practice.** April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. February 1, 2006 − Minor editorial amendments were made.
APPLICATION:	~~Minor editorial amendments made on February 1, 2006 do not affect the application of this policy~~**Applies to all decisions made on or after September 1, 2020**.

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***Rehabilitation Services & Claims Manual*, Volume II**

Additions in Highlighted Bold. Deletions Struckthrough.

#69.11 Permanent Disability Lump Sum Compensation ~~and Permanent Disability Compensation for a Fixed Term~~

Section 200(2) provides:

> If a worker has received a lump sum in place of the periodic payments that otherwise would have been payable for a permanent disability, the worker is deemed, for the purposes of subsection (1), to still receive the periodic payments.

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

In the case of a reopening of the same claim within three years, any previous lump-sum payment (in place of a permanent disability periodic payment) will be deducted from the current daily wage-loss benefit payments. The same position exists in respect of reopenings of the same claim after three years where the worker's pre-injury earnings are used to calculate benefits. If, however, in the case of a reopening after three years, wage-loss benefits for a recurrence of temporary disability are based on the worker's current earnings under the terms of sections 193(1) and 193(2), any previous lump-sum payment (in place of a permanent disability periodic payment) will not be deducted in accordance with section 193(3), except to the extent that the combined total exceeds the maximum wage rate in effect at the time of the recurrence.

~~If there is a recurrence after three years and term permanent disability benefits remain applicable and are being considered for their significance under section 192(2), the term permanent disability benefits should be converted to a notional life value for that purpose.~~

While the question ~~of~~ whether ~~to issue~~ a lump-sum payment **is deducted** is determined by its monthly equivalent at the time of the commutation ~~(under policy item #45.00)~~, the amount actually deducted ~~on a subsequent claim to ensure that the worker does not receive more compensation in total than the current maximum~~, 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.

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Rehabilitation Services & Claims Manual, Volume II

Additions in **Highlighted Bold**. Deletions ~~Struckthrough~~.

EFFECTIVE DATE:	**September 1, 2020**
CROSS REFERENCES:	Policy item #45.00, *Lump Sums and Commutations*; Policy item #45.10, *Permanent Disability Periodic Payment Categories/Lump Sum Compensation*; Policy item #70.20, *Reopenings Over Three Years*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	**September 1, 2020 – Policy amended to remove a spent provision, and reverse a housekeeping change.** April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1.
APPLICATION:	**Applies to all decisions made on or after September 1, 2020.**

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***Rehabilitation Services & Claims Manual*, Volume II**

Additions in Highlighted Bold. Deletions Struckthrough.

#114.40 Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability

1. Overview

Section 240(1)(d) 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 240(1)(d) reserve.

The intent of section 240(1)(d) is to give reassurance to potential employers that in employing workers with pre-existing diseases, conditions or disabilities, they will not incur undue costs in respect of possible future injuries that are enhanced as a result of the pre-existing diseases, conditions or disabilities.

If a claim is accepted under the *Act* for a personal *injury*, mental disorder or occupational disease, the Board provides cost relief under section 240(1)(d) for any portion of a compensable *disability* that is enhanced by reason of a pre-existing disease, condition or disability. Section 240(1)(d) cost relief decisions do not impact a worker's entitlement to compensation.

The Board is responsible for initiating section 240(1)(d) cost relief considerations with or without a specific request or application by an employer, and to decide upon the applicability of the section on a claim.

This policy applies to all employers, including deposit class employers, except for the Federal Government. As the Federal Government does not contribute to the Accident Fund, no relief of costs under this section can be made where the Federal Government is recorded as the injury employer.

2. Eligibility

Cost relief consideration does not occur on claims where wage loss ended and/or permanent disability benefits were established on or before December 31, 1993.

Where benefits were paid between January 1, 1994 and September 27, 2002, an employer was eligible for cost relief consideration under now section 240(1)(d) in two situations:

a) on all claims where there had been 13 or more weeks of temporary total and/or temporary partial disability benefits paid;

b) permanent disability benefit had been granted.

Where benefits are paid on or after September 28, 2002, an employer is eligible for cost relief consideration under section 240(1)(d) in two situations:

a) on all claims where there had been 10 or more weeks of temporary total and/or temporary partial disability benefits paid;

b) permanent disability benefits have been granted.

Cost relief can be considered on claims where the pre-existing disease, condition or disability arose from an earlier compensable injury or disease with the same employer, where the date of injury or disease, for the injury or disease on which relief is sought, is on or after July 1, 1998. The date of the disease, for the purpose of this paragraph, is the date that the first claim document is registered at the Board.

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 240(1)(d).

1. Was there a pre-existing disease, condition or disability, and if so, to what extent?

A “pre-existing” disease, condition or disability is one that exists before the compensable injury and is established by a confirmed diagnosis or medical opinion. It does not have to be symptomatic prior to the compensable incident, nor does there have to be previous medical treatment or disability related to the pre-existing disease, condition or disability, for it to be considered for the purposes of relief of costs under section 240(1)(d).

If a worker 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 240(1)(d) does not apply. The fact that a disability has been enhanced by factors other than a pre-existing disease, condition or disability is not a ground for relief under section 240(1)(d).

2. Was the worker's compensable disability enhanced by reason of a pre-existing disease, condition or disability, and if so, to what extent?

"Enhanced" can mean either the prolongation of recovery or the extent to which the compensable disability is made worse, due to the pre-existing disease, condition or disability.

Evidence that may be considered in determining the degree of prolongation or worsening of a disability includes:

- medical opinion regarding the "normal" recovery time for the particular type of injury;
- medical opinion regarding the "normal" post-surgical recovery time;
- the requirement of additional health care services (physiotherapy, hospitalization, etc.); and
- medical evidence contained on the claim.

All relevant factors are considered in the decision-making process.

If the severity of the compensable accident, incident or exposure was relatively minor, but there is evidence that the recovery period was prolonged, or the temporary or permanent disability was made worse, by reason of a pre-existing disease, condition or disability, cost relief under section 240(1)(d) will clearly be applicable.

3. How severe was the incident initiating the claim in question?

If there is confirmation of a pre-existing disease, condition or disability of a minor degree, but the incident which precipitated the compensable claim was of a severe nature, cost relief under section 240(1)(d) will not normally be applicable.

Since section 240(1)(d) specifically refers to the enhancement of "disability", it has no application in fatal cases or in cases where only health care benefits are payable.

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.

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The grid below is one tool that may be used to determine the amount of cost relief to be granted to an employer. It plots the medical significance of the pre-existing disease, condition or disability against the severity of the accident, incident or exposure resulting in the compensable disability.

Medical Significance of Pre-existing Disease, Condition or Disability	Severity of Accident, Incident or Exposure	Percentage of Cost Relief
Minor	Minor	50%
	Moderate	25%
	Major	0%
Moderate	Minor	75%
	Moderate	50%
	Major	25%
Major	Minor	90-100%
	Moderate	75%
	Major	50%

Medical Significance

A determination of the medical significance of the pre-existing disease, condition or disability is based on a review of the medical evidence and, where applicable, an opinion from the Board.

Severity

The severity of the accident, incident or exposure is generally determined by a review of the factual evidence, including the mechanics of the injury, the activity the worker was undertaking at the time of the injury and the conditions of the worksite.

The following definitions will assist in assessing the severity of the accident, incident or exposure:

"Minor" severity is expected to cause either no disability or a minor disability.

"Moderate" severity is expected to cause a disability.

"Major"	severity is expected to cause serious disability or probable permanent disability.

Percentage

How much disability stems from the compensable injury and how much from the enhancement of the disease, condition or disability and, therefore, to what extent costs should be charged under section 240(1)(d) can never be more than an estimate and will always be difficult to determine.

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

In cases of continuing wage-loss benefits and health care benefits, it may be appropriate for the Board to determine that after a particular point in time, all the costs are charged under section 240(1)(d). Alternatively, it may also be determined that a percentage is relieved from a certain time onwards.

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

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

In respect of permanent disability benefits, it is necessary for the Board to establish a percentage of cost relief to be granted based on the applicable medical evidence. It is noted that 100% cost relief cannot be granted for permanent disability benefits, as this would imply that no portion of the permanent disability resulted from the work-related injury.

5. Timing of Cost Relief Decisions

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

a) there being sufficient evidence to make a determination on whether the compensable disability was enhanced by reason of a pre-existing disease, condition or disability; 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 if the impact of the pre-existing disease, condition or disability on the compensable disability is not yet clear, or major diagnostic procedures have been scheduled that would clarify the existence, and/or extent of any pre-existing disease, condition or disability.

6. Communication of Cost Relief Decisions

The Board notifies the eligible employer of all section 240(1)(d) cost relief decisions.

If there is a disagreement with such a decision, the employer may request a review by the Review Division. ~~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~~**September 1, 2020**
CROSS-REFERENCES:	Policy item #97.30, *Medical Evidence*, of the *Rehabilitation Services & Claims Manual*, Volume II.
HISTORY:	**September 1, 2020 – Policy amended to remove a spent provision.** April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. May 1, 2011 – Housekeeping amendments to remove references to specific job titles, departments, appellate bodies and update references to external government bodies. April 8, 2005 − Housekeeping amendments; combination and replacement of policy items #114.40A, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*, #114.40B, *Enhancement of Disability by Reason of Pre-Existing Disease, Condition or Disability*, #114.43, *Procedure Governing Applications under Section 39(1)(e)*, and then #114.50, *Sections 39(1)(d), 39(1)(e) and Federal Government Claims* of this *Manual*; incorporated policy previously set out in Panel of Administrators' Resolution No. 1998/04/23-03 *Re: Section 39(1)(e)*: section 240(1)(d) cost relief consideration does not occur on claims where wage loss ended and/or permanent disability compensation was established on or before December 31, 1993; on or after July 1, 1998, section 240(1)(d) cost relief consideration is available for claims in which the pre-existing disease, condition or disability arises from an earlier compensable injury or disease with the same employer as the compensable injury or disease for which relief is sought; incorporated portions of, and retired from policy status, *Workers' Compensation Reporter* Decision No. 271, [1971] 4 W.C.R. 10; further amendments clarified the evaluation process for allocating cost relief. This policy continues the substantive requirements as they existed prior to the effective date.
APPLICATION:	Applies to all decisions **made** on ~~and~~**or** after ~~March 1, 2005~~**September 1, 2020**.

APPENDIX 2

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APPENDIX 3, PERMANENT DISABILITY EVALUATION SCHEDULE
***Rehabilitation Services & Claims Manual*, Volume II**

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II. Application of the Schedule

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~~ **Lower** Extremit**y**~~ies~~; and
- Fractures of the Pelvis: Section VII. Pelvis.

. . .

EFFECTIVE DATE:	~~December 1, 2019~~**September 1, 2020**
AUTHORITY:	Sections 195(1) and 195(3) of the *Act*
CROSS REFERENCES:	Policy item #39.10, *Permanent Disability Evaluation Schedule*
HISTORY:	**September 1, 2020 – Policy amended to correct a cross-referencing error.** April 6, 2020 − Housekeeping changes consequential to implementing the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. December 1, 2019 – Set the rating for comminuted calcaneal fractures at 7%; clarified ratings for nerve root and peripheral

nervous system conditions affecting part of the nerve's distribution; and made minor editorial changes.
January 1, 2019 – Updated Vision and Loss of Strength. Revised a typographical error in Vestibular Disorders.
May 1, 2017 – Added obturator nerve to section VIII. Peripheral Nervous System Conditions. Changed the percentages of disability for permanent tracheostomy, significant tracheal obstruction and minor tracheal obstruction; changed the range of motion rating threshold for the spine and limbs; and made minor consequential amendments including typographical errors and edits for clarification.
January 1, 2015 – consolidated and incorporated policy items #31.90, #39.11, #39.12, #39.13, #39.20, #39.21, #39.30, #39.31, #39.32, #39.40, #39.41, #39.42, #39.43, and #39.44 of the *Rehabilitation Services & Claims Manual,* Vol II., and portions of the *Additional Factors Outline*.
January 1, 2007 – policy changes to add item 81 Asthma and item 82 Contact Dermatitis to the Permanent Disability Evaluation Schedule.
August 1, 2003 – substantial changes to the Permanent Disability Evaluation Schedule including changes to the percentage(s) of disability for partial amputation of the digits, spine and pronation/supination. Housekeeping changes.
July 16, 2002 – housekeeping changes.

APPLICATION: Applies to all decisions made on or after ~~December 1, 2019~~**September 1, 2020**.