CHAPTER SEVEN: WORKERS' COMPENSATION

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CHAPTER SEVEN: WORKERS' COMPENSATION

I. INTRODUCTION

This chapter covers basic legislation, policy and procedures associated with appeals under *Workers' Compensation Act*, RSBC l996, c 492 [WCA].

The WCA is a provincial statute creating a regulatory body called the Workers Compensation Board of B.C. Since 2003, this body works under the name of "WorkSafe B.C." and is referred to as "the Board" or WCB in this section. The Board has exclusive jurisdiction over compensation for workplace injuries amongst other duties. The Board's origins are perhaps more interesting than its current form suggests.

Some of the earliest forms of workers' compensation started with pirates in the pre-Revolutionary Americas. A pirate who lost an eye was entitled to 100 pieces of eight, roughly one year's pay.[1] With the industrial revolution, more evolved workers' compensation schemes followed in Europe and eventually spread back to North America where they are now mandatory across Canada and the United States.

Today's workers' compensation schemes, including BC's, are based on the historic trade-off: employers fund a no-fault insurance scheme benefitting workers and in exchange workers give up their right to legal action against their employer for work-related injuries and occupational diseases [WCA s 10]. Ideally, this approach offers several benefits. It takes workplace injury claims out of the courts, reducing clutter for them and cost and delay for the workers. It gives greater certainty of coverage to workers and streamlines the compensation process. Finally, like any insurance scheme, it spreads losses amongst employers and eliminates the concern about ruinous claims. Unfortunately, reality often falls short of these ideals and, especially in light of changes since 2002, injured workers often require help and even representation.

The Board's other duties consist of:

> **Regulation of Occupational Health and Safety (OH&S):** In BC, the Board is responsible for workplace health and safety regulations, investigations, and enforcement as set out in Part III of the WCA and in the *Occupational Health & Safety Regulation*. While most enforcement orders and penalties are against employers for safety violations, orders may also be issued against workers. Under the WCA, workers are entitled to refuse unsafe work and to be protected from retaliation for reporting unsafe work practices.
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> **Employer Assessments**: The WCA grants specific powers to the Board to set rates and collect assessments from employers to create an Accident Fund. The Accident Fund must be sufficient to finance the compensation system and each employer is assessed annually based on a complex formula (see below). The WCA requires the Board to operate a fully funded system.

A. *Scope of This Section*

> This section advises workers and their representatives on the overall structure and basic procedures of the Board and its appeal body, the Workers Compensation Appeals Tribunal [WCAT]. It is intended to assist in working on cases and appeals arising from Board decisions made under the WCA. The vast majority of appeals involve Board decisions denying injured and disabled workers particular compensation benefits. This is not surprising given that Board policies are often complex and difficult to understand and that about 100,000 compensation claims are filed by injured workers every year, with about half of these claims involving a serious injury or disability.

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[1] Christopher J Boggs, "Workers' Compensation History: The Great Tradeoff!", online: (2015) Academy of Insurance <http://www.insurancejournal.com/blogs/academy-journal/>.

Therefore, the primary focus of this material is on Compensation matters which may be at issue in appeals. Assessment and OH&S issues are addressed briefly at the end of the chapter. The Appendices provide information for referrals and community resources. In particular, the WCA requires the Board, through its Accident Fund, to support the Employers Advisors and Workers Advisors who can provide employers and workers with free legal assistance. However, the extent of the assistance provided by these Advisors changes from time to time and between locations.

II. GOVERNING LEGISLATION AND RESOURCES

A. *Legislation*

The ***Workers Compensation Act*** **[WCA]** is the legislation which creates and governs the Board. In 2002 and 2003, the WCA was substantially amended and the key transition date is **June 30, 2002.** Workers who were injured before or on June 30, 2002 (with a few exceptions), have the former WCA apply to their claims whereas workers who were injured after this date are under the amended or "new" WCA.

The new WCA revised sections 99 and 250 of the Act to make Board policy binding on all Board decision-makers and appeal bodies (i.e. WCB and WCAT). The courts have since determined that the effect of these provisions is to give Board policy a legal status equivalent to subordinate legislation (see below).

The WCA amendments also changed the appeal structure for Board decisions. After March 1, 2003, there are two levels of appeal for most Board decisions:

i. an internal review at the Review Division (RD); and
ii. an external de novo appeal at WCAT, which is an independent tribunal.

In 2004, the ***Administrative Tribunals Act*****, SBC 2004, c 45 [ATA]** came into effect. The ATA applies to all administrative tribunals in B.C., including WCAT. The ATA sets out certain procedural requirements for WCAT and also sets a 60-day time limit for filing a judicial review from a WCAT decision. The ATA does not apply to Claim or Review Division decisions.

OH&S matters are primarily dealt with through the OH&S Regulation, although there is also a Prevention Manual.

Citations for the WCA, key amendments and other relevant legislation are attached in the Appendix. All legislation and Board policies are available on the Board website at www.worksafebc.com. Applicable ATA provisions and their effect on WCAT procedures are also incorporated in WCAT's *Manual of Rules, Policy and Procedures* [MRPP], available on the WCAT website at www.wcat.bc.ca.

B. *Binding Policy for Compensation Claims and Appeals: RSCM II*

Section 99 of the WCA requires the Board to apply any applicable Board policy which has been passed by the Board of Directors. This means that published Board policy is binding on all Board decision-makers, including the Review Division; a similar provision makes Board policy binding on WCAT [section 250].

Section 99 of the WCA also states that all decisions "shall be given according to the merits and justice of the case and where there is a doubt as to any issue and the disputed possibilities are evenly balanced, the issue shall be resolved in accordance with that possibility which is favourable to the worker". This means that in WCB cases there is a unique standard of proof: the "as likely as not" standard. This is less than the balance of probabilities ("more likely than not") and, properly applied, should favour compensation for the injured worker.

In practice, Board policy confines, or attempts to confine, the nature of relevant evidence and to provide the framework for how evidence is to be assessed and weighed. Therefore, in appeals, it is important to identify the correct applicable Board policy whether or not it is identified in the initial Board decision.

Compensation policy is set out in the **Rehabilitation Services and Claims Manual, Volume II [RSCM II]**. The current RSCM II is available at www.worksafebc.com under the "Law and Policy" tab, followed by the "Compensation Policies" link under "Claims & Rehabilitation". On the sidebar, there are tabs for both RSCM Volumes I and II. Volume I applies to claims initiated before June 30, 2002 [RSCM I] and Volume II applicable to any claims initiated after June 30, 2002.

The RSCM II has eighteen chapters. Each chapter focuses on a particular entitlement issue or benefit and contains the policies relating to that issue. Each policy is numbered and dated and is typically 1-3 pages long. The RSCM II index (also available through the RSCM II link) is very helpful for locating any relevant chapter and policy.

Board policies change frequently. Each new version of a policy is passed by the Board of Directors and is published with both a specific effective date and a determination as to whether or not the changes apply to appeals. This information is set out at the end of each policy. Each new Board policy is incorporated into the electronic version of the RSCM II available on the Board website. When handling an appeal, students should determine the relevant applicable policy (especially for old claims) and should also review the electronic version of newer policy to ensure that it is still current. The Board website also contains all the former or "archived" policy manuals so that any relevant policy is accessible, even for old claims.

If a particular Board decision quotes part of a policy, it is good practice to read the whole policy and also to look at the surrounding policies to understand the full framework for that type of benefit. Also, although a particular policy may be quoted in a decision, the decision-maker may or may not have applied the right policy. It is best to assess the worker's issue and determine whether or not alternative policies may be the correct applicable policies.

Lastly, Board policy must be consistent with the WCA. If someone considers that a Board policy is inconsistent with the WCA, they are entitled to challenge that policy in a WCAT appeal in which it is relevant. If the WCAT panel agrees that the policy is not supported by the WCA, the panel will refer the matter to the WCAT Chair; if the Chair agrees, they will refer the policy to the WCB's Board of Directors for ultimate determination and possible policy change (s. 251, WCA).

C. *Non-Binding Practices*

Both WCB and WCAT also provide useful interpretive guides that combine policy, important decisions, and best practices. WCB issues Practice Directives (PD) that advise on many particularly complex issues such as chronic pain, mental disorders, and overpayments. These are accessible through the "Law and Policy" tab at www.worksafebc.com under the title "Compensation Practice Directives and Reference Guides". WCAT's guidelines are published in the MRPP discussed above. These publications can be extremely useful and are worth exploring though neither are binding on their respective bodies.

D. *Arguing Medical Evidence*

As in any legal arena, at all stages of the Workers' Compensation process it is vital to support claims with evidence. Often this can be especially challenging when dealing with medical issues for many reasons. These issues require specialized knowledge, they often do not lend themselves to certainty even for professionals, and most injured workers have limited time and money to spend collecting evidence. Conversely, WCB has salaried Board Medical Advisors (BMA) and WCAT is "presumed to be an expert in all matters over which it has exclusive jurisdiction" (*Fraser Health Authority v. Workers'*

Compensation Appeal Tribunal, 2014 BCCA 499 (*Fraser Health*)). Nevertheless, WCB and WCAT are not presumed to have medical or scientific expertise and as such they are not permitted to ignore uncontradicted expert advice (*Page v. British Columbia (Workers' Compensation Appeal Tribunal)*, 2009 BCSC 493) particularly in light of the "as likely as not" standard. While it may be useful to document subjective claims of injury, pain, and limitations, workers should bring as much objective expert evidence as possible. This may include physiotherapists, massage therapists, chiropractors, and dentists in addition to a family doctor. If necessary and possible, ask to be referred to a specialist.

Also recall that causation does not need to be proved to the level of scientific certainty and that the finder of fact is permitted to make common sense inferences (*Snell v Farrell*, [1990] 2 SCR 311; *McKnight v. Workers' Compensation Appeal Tribunal*, 2012 BCSC 1820)

III. LIMITATION PERIODS AND TIMING OF DECISIONS

WCB deadlines are both short and generally strict so while there are reminders throughout this section outlining relevant deadlines, they are all collected here for quick reference. Steps 3-7 are only as applicable.

1. Report the claim to employer: Do this **as soon as possible**. Even small delays can prejudice your claim.

2. File a claim with WCB: Any claim must be filed within **1 year** of the date of injury.

3. Reconsideration of Board Decision: The Board may reconsider any past decision so long as it the inquiry is completed within **75 days**.

4. Appeal to Review Division (RD): **The time limit for applying for an Internal Review is 90 days.** Workers seeking appeal must always file a Request for Review within 90 days of the date of the decision. Workers are not required to submit arguments at the Request for Review stage, but only to file the Request for Review form, which includes some basic information and a brief description of what denied benefits they are seeking and why. Therefore, if the 90-day limit is approaching, it is far more important to submit the Request for Review on time than it is to ensure you have fully stated your reasons for review – those could always be added to later. If a worker has missed the 90-day time limit, they should file the review and request an extension of time providing reasons why they are late—the Chief Review Officer can grant an extension of time if good reasons are shown.

   Most Internal Review Decisions must be made within 5 months (150 days). The WCA now requires that the internal review officers complete their review of the Board's decision within **150 days** of the date when the request for review was made.

5. Reconsideration by Review Division: Limited inquiry but **must be completed within 23 days** of original RD decision (see VII.A).

6. Appeal to WCAT: **The time limit for appealing to WCAT is 30 days.** If a worker or employer is unhappy with the outcome of the internal review, they must appeal to WCAT within 30 days of the RD decision being issued.

   Most WCAT Decisions must be made within 6 months (180 days) of receiving the Claim File from the Board. This general time limit can be extended by the chief review officer due to the complexity of the matter, a request by the worker or employer, or the need to await a pending decision on another claim raising similar legal or policy issues.

   Direct Appeals from WCB to WCAT (90-day time limit). There are certain types of appeals which go directly to WCAT without the decision first being reviewed internally. These include appeals over a decision regarding alleged discrimination by an employer against a worker for making a claim, or reporting a safety violation.

7. Reconsideration by WCAT: Very limited inquiry that can primarily only be used to correct minor clerical errors unless there is new evidence or procedural unfairness (see VII.G). Reconsideration for correction of a clerical error **must be completed within 75 days** of the original WCAT decision. Reconsideration by WCAT for new evidence of procedural unfairness has no time limit.

8. Judicial Review: Party must file a petition for Judicial Review within **60 days** of date of a WCAT decision being appealed.

IV. INTRODUCTION TO COMPENSATION CLAIMS FOR INJURED WORKERS

A. *Introduction*

Sections 96 and 113 of the WCA give the Board exclusive jurisdiction over workers' compensation matters. The courts have generally respected this strong privative clause.

Section 96 specifically grants the Board the exclusive jurisdiction to inquire into, hear, and determine:

- whether an injury has arisen out of or in the course of an employment;
- the existence and degree of disability by reason of an injury;
- the permanence of disability by reason of an injury;
- the degree of reduction of earning capacity by reason of an injury;
- the average earnings of a worker, for the purpose of levying assessments, and the average earnings of a worker for purposes of payment of compensation;
- the existence of the relationship of a member of the family of a worker as defined by the Act;
- the existence of dependency;
- whether an industry is within the scope of the Act, and the class to which an industry should be assigned for the purposes of the Act;
- whether a worker is in an industry within the scope of the Act and entitled to compensation under it; and
- whether a person is a worker, a subcontractor, a contractor or an employer within the meaning of the Act.

Section 113 of the WCA gives the Board jurisdiction over compensation in relation to workplace health and safety.

Once an injured worker applies for compensation, the Board will begin to assess whether or not to accept the claim. Once the claim is accepted, the Board will then adjudicate the worker's entitlement to the type of compensation benefits listed above.

B. *Overview: Initial Acceptance or Denial of a Compensation Claim/Disclosure & Appeals*

After a worker makes an application for compensation, a Board officer issues a decision (usually in writing) accepting or denying the claim. For a compensation claim to be accepted, the Board must generally find:

- STATUS: The applicant is a "worker" covered under the Act.
- DISABILITY: The applicant suffered a personal injury or an occupational disease, causing disability.
- CAUSATION: The worker's disabling injury or disease was caused by work.
- TIME LIMITS AND PROCEDURES: The worker submitted a timely and proper application.

If a claim is denied by the Board, it is typically because one or more of the above conditions was not met. The Board decision typically sets out the reason why the claim was denied and cites the relevant policy from RSCM II. However, the evidence on which the decision is based may or may not be summarized in the decision.

All the evidence on which the decision is based will be in the claim file, which may also include memos from case managers (CMs) and clinical opinions from Board Medical Advisors (BMAs). The claim file may also contain detailed phone memos providing the CMs with a summary of the worker's evidence. The claim file evidence as a whole provides the basis for the Board's decision and is evidence which will be available and considered by the appeal bodies, RD and WCAT.

Workers are entitled to a copy of their claim file (paper or CD) on request and will also automatically be sent a copy of the claim file if they file an appeal. In addition, the worker may obtain online access to parts of their claim file by calling the Board. These matters are covered in the section below on Access to Files (7-31). Disclosure may be given directly to the worker's representative if the disclosure request or appeal notice is accompanied by a valid authorization of representation, signed by the worker. [Authorization forms are available on the Board website].

If the worker (or the employer) disagrees with the Board's decision, he or she may appeal the decision to the Review Division (RD) **within 90 days of the Board decision**. The RD is a review body internal to the Board; links to RD material, including RD appeal forms, are available on the Board website (www.worksafebc.com/en/review-appeal). The RD must issue a decision within 180 days of the appeal being filed. The RD decision may then be appealed to an independent tribunal, the Workers' Compensation Appeal Tribunal (WCAT) within **30 days of the RD decision**. WCAT appeal forms are available on the WCAT website: www.wcat.bc.ca. See **Section VI: Appeals** for more details.

Section 55 of the WCA requires that generally, a worker must apply for compensation **within one year** of the date of injury unless there are "exceptional circumstances." If a worker's application has been denied because of a late application, please consult s. 55 of the WCA and Policy #93 of the RSCM II to assess what evidence of "exceptional circumstances" may be relevant in that case.

C. *Overview: Worker Disability and Compensation Benefits*

Of the 100,000 workers injured on the job in B.C. every year, about half suffer minor or inconvenient injuries and return to their pre-injury employment in quick order. Most of these claims are accepted by the Board for health care benefits only (medical treatment, medication, etc.).

Of those workers whose injuries are more serious, there are several common profiles of disability and recovery. The following examples are to illustrate common compensation benefits and scenarios for disability.

- The worker suffers a broken wrist in his dominant hand and cannot perform his job duties as a result. His doctor recommends a certain number of weeks to recover after which he is cleared to return to work (RTW), full duties. The worker makes an application for compensation. If his claim is accepted, the Board sets a short-term wage rate (STWR) on his claim (based on his average earnings) and the worker is paid temporary wage loss benefits (TWL) at this rate for his days of lost work. The Board also covers any health care costs such as treatment or medication. If there are no permanent medical consequences to this injury and the worker returns to work full duties, the Board issues a decision that the injury is "resolved" and his claim is closed. The worker is not referred for any other benefits such as Disability Awards (DAs) or Vocational Rehabilitation (VR).

- The worker suffers a more serious injury to his hand (e.g. a crush injury). If his claim is accepted, he again receives TWL for his time away from work. However, after 10 weeks, the Board issues a new long-term wage rate (LTWR) based on a more complex formula in law and policy. At a discretionary point, the Board considers that the worker's condition is no longer "temporary" and must make one of the following decisions about the worker's medical condition. Either:

    a. His injury has "resolved" with no permanent impairment and he can RTW and perform full duties. In this case (as above), the Board will issue a "resolve" decision ending his TWL benefits and his file will be closed; or

    b. His injury is not fully resolved and he is left with some permanent functional impairment (PFI). In this case, the Board will issue a "plateau decision", setting a date at which it considers that the worker's condition is no longer temporary but it has reached a medical "plateau" (that is, the condition will not significantly change in the next year). This "plateau" decision also ends TWL benefits on the plateau date but will also refer the worker to DAs to assess the nature and severity of this permanent impairment. In a separate decision, the DA will rate his impairment according to a schedule and award the worker PFI pension (impairment % compared to a healthy person) in a "PFI decision". The PFI pension is awarded regardless of whether the worker returns to work or not as it is compensation for the physical impairment, not for lost wages.

  The plateau decision also sets out whether the Board thinks that the worker can return to his pre-injury job, performing full duties, with the impairment. If the worker can return to his pre-injury work, the Board does not need to retrain him and there is no referral made to VR.

  However, if the Board considers that the worker cannot return to full duties with his impairment, the "plateau decision" will state this and the worker will be referred to VR for further help with employment.

  The VR process is set out below and goes through five phases. The first phase is to see if the employer can or will accommodate the worker and his impairment. If there is no accommodation and the worker does not have a job to return to, VR goes through further phases to assesses what VR assistance the Board should provide to help the worker become employable, given his permanent injury. VR benefits are discretionary but typically include a VR plan for the worker to re-train and/or have a job search and wage loss benefits for this period of VR time. If successful, VR results in the injured worker successfully adapting to employment with a permanent injury.

It is possible that VR is not successful or that a seriously injured worker is simply too disabled to ever be competitively employable. In these cases, the Case Manager (CM) must decide if the impact of the worker's disability is "so exceptional" that a PFI pension is inadequate financial compensation for the worker's loss of employability. In such cases, the worker may be entitled to be assessed for a wage replacement pension, known as a "loss of earnings" or LOE pension. The "LOE pension decision" is issued by the CM, either as part of the plateau decision or after a VR process. If awarded, full LOE pension benefits are equivalent to ongoing TWL benefits. However, the criteria for having an LOE assessment are quite onerous under the new WCA and they are rarely awarded.

D. *Overview: Claims Procedures & Process*

Reporting the Injury

All injuries that cause a loss of work (or which could lead to a future claim) should be reported **as soon as possible** by the worker or, if death results, by the worker's dependants, to the superintendent of the place of employment, first aid attendant, or other official. Claims have been denied (at least until an appeal took place) because a worker waited even a few days, hoping the pain would go away. In all but the most minor cases, workers should also seek medical attention promptly.

The employer must complete a report to the Board **within three days** of receiving the worker's report, or immediately if death results. The attending physician also completes a Physician's First Report within three days of first seeing the worker, and fills out progress reports after each visit.

Making a Claim

An worker has **one year** to make a claim for compensation under s. 55 of the WCA. This may be extended to three years in certain circumstances. In extreme cases, the Board may consider even longer extensions.

Workers can call the WCB directly to report an injury and file a claim. Teleclaim is available to workers across the province, Monday to Friday, from 8 a.m. to 4 p.m. See the Board website for current contact details. Teleclaim is designed to simplify the process, reduce the amount of paperwork, and provide a personalized service based on each individual's needs. Before calling the Board to report an injury, the worker should write down the key information about the job, how the injury occurred, and what the doctor has said about the condition. The worker's statement during a Teleclaim report will form part of the claim file, and could be used as evidence in future appeal proceedings. The Teleclaim transcript may be sent to the worker. If it is not sent, the worker should request a transcript.

Procedure After Application

The family doctor plays a crucial role in the worker's claim as well as his or her treatment. The WCA requires that the doctor file an initial report with the Board, as well as progress reports for each visit. Doctors are also required to give all necessary advice and assistance to a worker making an application for compensation, including furnishing proof that may be required. Some doctors are very helpful to injured workers, while others refuse to get involved in what they consider to be a legal issue. Such an attitude can be very harmful if there is a medical dispute between the Board and the worker.

The Board has extensive inquiry and investigative powers. It may require the worker to be medically examined by a WCB staff doctor or by independent consultants. WCB officers called Claims Adjudicators, Disability Awards Officers, and Rehabilitation Consultants decide

whether to accept the claim and what benefits, if any, should be paid. Although rarely used, the Board has the authority to conduct a formal inquiry at which the claimant and other witnesses are compelled to appear and be questioned. Important decisions occur at various times as a result of the interaction and correspondence between various WCB officers, the worker, the family doctor, and any specialist.

The Case Management Process

The WCB operates under a case management process in cases where the individuals are recovering from complex and costly injuries and illnesses. The key features of case management include a CM who oversees the delivery of services for the entire life of the claim. It is also supposed to include regular multidisciplinary team meetings, clinical care planning, site visits, and a return to work plan, which sets out expectations surrounding medical treatment, physical rehabilitation, and an RTW option. In theory, the worker, union or other representative, the worker's doctors, and the employer are all expected to participate. Advocates for injured workers have found that this crucial part of the case management model is rarely followed.

Claims Management Solutions

On May 11 2009, WCB launched a "Claims Management Solutions" (CMS) system to streamline and manage the claims process more effectively, and improve service to customers. CMS manages all data related to previous, current, and future claims and helps integrate services throughout the life cycle of a claim. It is supposed to result in faster case handling and claim payments, more support for injured workers, and less administrative work for employers and service providers. Workers can obtain real-time access to their claim file by registering online, and can authorize a representative to have access as well.

Initial Decisions

Most decisions are made by frontline WCB officers. The major issues to be decided are: whether the worker is covered by the WCA; whether the injury arose out of and in the course of employment; and what benefits the worker is entitled to. The most important WCB officers, and the decisions that they make, are as follows:

a) Case Manager (CM)

- accepts or rejects claims;
- approves wage loss benefits, determines the initial wage rate, and terminates or reduces wage loss benefits;
- investigates and decides "long term" average earnings, which are implemented ten weeks after the injury (eight weeks for injuries before June 30, 2002);
- approves or rejects operations or other major treatments;
- approves workers' expenses for WCB payment;
- determines when to terminate wage loss benefits because the worker's disability is considered to have "plateaued";

- generally, makes most decisions involving workers including whether to register the worker for vocational rehabilitation services and pension assessments; and

- determines whether the worker qualifies for an LOE pension because he or she has suffered a loss of earnings that is "so exceptional" that the functional pension does not adequately compensate for it.

b) Vocational Rehabilitation Consultant (VRC)

- Works with the worker, employer, and union (if any) to get the worker back to work as soon as medically possible, perhaps to a modified job;

- approves job retraining courses;

- determines training allowances (usually paid at wage loss levels) and expenses for attending courses;

- can agree to subsidize a new employer for a limited time;

- determines "continuity of income" benefits to bridge the gap between termination of wage-loss benefits and determination of a permanent pension; and

- assesses a worker's long-term employability, and the earnings he or she is considered capable of achieving after the worker has "maximized" his or her earning capacity in a suitable and available job. This assessment is the core of the Disability Awards Officer's decision concerning an LOE pension. While the decision is made by the Officer, who can reject the recommendation of the consultant, the consultant's assessment is a crucial step in the pension process.

c) Disability Awards Officer

- Determines the degree of permanent disability on a physical impairment basis; for workers whose permanent disability is considered to have occurred on or after June 30, 2002, this will determine the pension in the great majority of cases.

These WCB employees, together with a number of other WCB "players", interact considerably during initial decision processes. For example, a projected loss of earnings assessment, while made by a Disability Awards Officer, is based on a report from the Rehabilitation Officer stating which jobs are suitable and available to the worker, and what earnings can be anticipated. Throughout a claim, the Board's salaried medical staff (doctors, psychologists etc.) are consulted regularly regarding medical issues, and their advice is regularly accepted by the Board over that of the worker's own family doctor and specialist if there is a dispute.

d) EXCEPTION: Electing to Proceed Outside the WCB

In certain cases, a worker may choose to sue the person or company responsible for causing a work injury rather than making a claim for Workers' Compensation.

If the injury is caused by a person not covered by the WCA (i.e. a delivery driver injured by a private citizen in a motor vehicle accident), then the worker can elect to sue a non-covered "third party" instead of claiming compensation.

The Board can also sue the third party in the worker's name; this is termed "subrogation". If the worker claims compensation, the Board has exclusive jurisdiction to decide if it will take legal action against a third party. If it does take action and recovers more than the total value of the worker's benefits, the worker receives the difference minus a 29% administration fee. If the Board recovers less than the total value of benefits, the worker will keep the full compensation. A worker cannot waive or assign his or her right to compensation.

An "election" is an important and complex decision (see s. 10 of the WCA) and workers should be referred to the Workers' Advisors Office online at www.labour.gov.bc.ca/wab before deciding whether to claim compensation. If a worker chooses to pursue court action and is unsuccessful, or the award is less than he or she would have received under the compensation regime, the worker may still be able to receive compensation. However, the original claim for compensation must have been made within the time limits outlined above.

Acceptance or Denial of Claim

As noted above, there are several key issues involved in determining whether an injured worker's claim is accepted or denied.

e) Is the Applicant a "Worker" under the Act?

(1) General

The WCA was amended on January 1, 1994 to expand the range of workers covered**. All workers are now covered, unless specifically exempted.** Chapter 2 of the RSCM II sets out the general principles of inclusion and the exceptions. Even certain volunteers are covered, as are students engaged in work study programs that are approved by the Board. Before this amendment, most office workers and other white-collar workers were not covered. Since the amendment, only a few exceptions have been recognized, such as professional athletes who have accepted a high level of risk, casual baby sitters, and non-residents. Requests for exemptions may come from workers and employers, or may be initiated by the Board. Decisions regarding exemption status may be appealed.

One of the unintended consequences of this universal coverage is to further limit the injured worker's right to sue for damages, since it is most likely that the person responsible for the injuries will also be an employer or worker covered by the system. An extreme example of this was found in a malpractice case, *Kovach v Singh (Kovach v WCB)*, [2000] SCJ No 3 [*Kovach*]. In this case, and in a similar Saskatchewan appeal, the Workers' Compensation Boards held that doctors treating an injured worker could not be sued for malpractice under the tort system because the injured worker was in the "course of employment" while undergoing treatment. The SCC found that the decision of the Boards in those cases was not unreasonable. The Board has responded strongly to cases that stray from this position. They will not allow any recourse to the tort system and have reaffirmed this bar to lawsuits in the policy directives.

Some special cases are set out below, but at all times, the most recent version of policies in Chapter 2 of the RSCM II should be consulted if "worker status" is an issue.

(2) Workers in Federally Regulated Industries

While working in BC, workers in federally regulated industries are directly subject to the workers' compensation system.

(3) Federal Government Employees

Federal government employees are governed by the *Government Employees Compensation Act*, RS 1985, c G-5 which provides that injured federal government workers in a given province are to have their claims addressed by the provincial administrative body in that province, and are entitled to be compensated at a rate determined under the provincial workers' compensation scheme of the province in which they are employed (but paid out of a federal fund).

(4) Workers Who Suffer an Injury While Working Outside BC

Workers who suffer an injury while working outside BC may be covered if:

- they work in a compensable industry;
- BC is their place of residence and usual place of employment;
- the extra-provincial work lasts less than six months;
- the work is a continuation of their BC employment; and
- they are working for a BC employer (WCA s 8(1)).

(5) Workers Under the Age of Majority

Section 12 of the WCA states that a worker under the age of 19 is sui juris for the purpose of Part 1 of the Act, which means that workers who are minors are under no legal disability and are considered, for purposes of the Act, capable of managing their own affairs as if they were adults.

(6) Self-Employed

If a person is self-employed, the Board distinguishes between a principal of an incorporated company, a principal of an unincorporated business, including a family business, and a labour contractor.

In general, a principal of an incorporated company is considered a worker and the wage rate is set accordingly.

In general, a principal of an unincorporated business and a labour contractor are entitled to seek coverage with the Board by voluntarily registering with the Board and paying premiums for their own work

activities. This is known as "Personal Optional Protection" (POP). When a self-employed person with POP is injured, their claim is processed as if they were a "worker" under the Act (section 33.6) and their wage rate is set according to their level of POP coverage (policy #67.20, RSCM II). A labour contractor who does not have POP may be covered, as a worker, by the prime contractor.

The key issues in the acceptance of claims from self-employed persons tend to be the exact nature of their employment, their coverage and the appropriate wage rate. Practice Directive #C9-1 "Coverage and Compensation for Self-Employed Persons" sets out a helpful chart on the different types of self-employment and their coverage under the Act.

(7) Employers

Employers are also covered by and have duties under the WCA, including contributing to the Accident Fund based on compulsory assessments. The Board sets an assessment rate for each employer based on a complex system of classification relating to type of business and previous accident rates. Employers should be referred to the Employers' Advisors Office for specialized assistance, without charge, in these matters (see Appendix on Referrals).

f) Is the Applicant Disabled?

Before a compensation claim can be accepted, the Board must find that the worker's injury, death, or disease was disabling and that the disability occurred as a result of employment. The WCA addresses these matters differently for different types of conditions.

a. Section 5: personal injury (physical or physical/psychological)

b. Section 5.1: psychological injury only ("mental stress")

c. Section 6 (1): occupational disease (OccD) – no presumption of work causation

d. Section 6(3): OccD – presumption of work causation

e. Section 7: hearing loss

Detailed policies regarding each of these conditions are set out in the RSCM II. Chapter 3 sets out policy for personal and psychological injuries and compensable consequences. Chapter 4 sets out policy for all OccD, including repetitive strain injuries and hearing loss. Students handling appeals should note that most causation disputes come down to matters of evidence, and the policies provide important guidance on what evidence is required in each case.

(1) Injury or Disease or Both?

Because the statutory and policy requirements for an injury and OccD are different, it is important to consider the worker's disability under the correct relevant category. Sometimes this is not clear.

Policy #C3-12.00 has a helpful section on the distinction between an "injury" and a "disease". Some conditions, like tendonitis or hearing loss, can be either an injury or a disease, depending on the circumstances of the injury. For example, hearing loss from a single occurrence like an explosion is treated as an injury while gradual loss of hearing due to occupational noise is treated as a disease.

Sometimes, a worker is disabled by a combination of a slow developing disease followed by a single event. The combination results in a significant disability, although neither event by itself would have been disabling. This is a difficult causation case. While the single event may not be sufficient to injure a healthy person, the worker is "working hurt" so a minor event is sufficient to disable him. This is the compensation version of the "thin skull" victim in tort law. The Board will likely not accept work causation in the initial decision and deny the claim as not meeting the causal standard under WCA s. 5. On appeal, the best way to address this matter is to have good evidence, preferably medical evidence, of the worker's medical condition prior to the single event.

In some case, the worker's pre-existing condition is actually a developing OccD, such as gradual onset repetitive strain or gradual hearing loss. In these cases, you may wish to ask the Board to accept the pre-existing condition as a compensable OccD under section 6. If the Board denies this aspect as well, you may appeal this denial and join the two appeals together at the RD or WCAT so an appeal panel may consider the "whole worker".

(2) Compensable Aggravation

For both injuries and OccD, it is also recognized that the worker can have a pre-existing condition which is aggravated or activated by the compensable injury or disease. For injuries, the relevant policy is set out in #16.00 RSCM II; for OccD, policy is set out in #26.55.

In both cases, if the pre-existing condition meets the test for compensable aggravation, this requires a "decision" separate from a simple acceptance "decision". For example, the Board may deny that a slip and fall was sufficient to cause a meniscus knee tear in a healthy worker; however, if the worker had pre-existing knee problems, the same claim could have a separate decision accepting an "aggravation" type injury.

An "aggravation" approach applies when the worker has a pre-existing but non-disabling condition. After acceptance, the worker's injury is dealt with like any other claim and the whole disability is compensable.

However, if the worker has a pre-existing disabling condition and becomes further disabled in the same body part through a work injury, the Board will apply section 5(5) of the WCA or "proportionate entitlement" whereby compensation is paid only for the increase in disability, rather than the whole disability.

(3) Jurisdiction

Work outside of BC is regarded as non-work exposure for compensation purposes. However, workers' compensation boards across Canada have entered into an "interjurisdictional agreement" that provides for reciprocal coverage of some disabilities arising from work exposure or activities in

different jurisdictions, and also enables the ruling Board to administer a claim in another province. The Board may try to apportion benefits in cases where the disability is partially caused by non-work or out-of-jurisdiction factors according to the percentages of causation – at least when assessing a pension – although it is not clear that the Act authorizes this.

g) Is the Disability Caused by Work?

Under section 5 of the WCA, personal injury or death must arise out of, and in the course of, employment in order to be compensable.

"Arising out of employment" relates to causation and means that the work must have causative significance to the injury. Not all injuries at work are caused by work, as some are naturally occurring conditions which would have happened in any event. For example, a worker with heart disease, who is working in a sedentary job, may have a heart attack at the office. There is likely nothing in the work activity which would have causative significance for this injury.

"In the course of employment" relates to the employment relationship at the time of injury.

NOTE: There is a statutory presumption that if an injury is caused by an accident at work, the injury is presumed to have occurred in the course of employment [WCA section 5(4)]. An accident can include someone else's intentional act.

The determination of whether an injury arose out of and in the course of employment is set out in policy C3-14.00 and can be made with reference to factors such as:

- whether the injury occurred on the premises of the employer;
- whether it occurred in the process of doing something for the benefit of the employer;
- whether it occurred in the course of action taken in response to instructions from the employer;
- whether it occurred in the course of using equipment or materials supplied by the employer;
- whether the risk to which the worker was exposed was the same as the risk to which he or she is exposed in the normal course of production;
- whether the injury occurred during a time period for which the worker was being paid;
- whether the injury was caused by some activity of the employer or of a fellow worker;
- whether the injury occurred while the worker was performing activities that were part of their regular job duties; and

- whether the injury occurred while the worker was being supervised by the employer.

This list is not exhaustive, and alone, none of the above factors are conclusive.

Chapter 3, RSCM II sets out further and detailed criteria for acceptance of a claim under section 5 of the WCA. Current policy states that the injury need not occur while the worker is engaged in specific productive acts, so long as it occurs within the broad circumstances of carrying out the employment duties. An injury which is incurred while commuting is generally not a compensable injury; however, travelling may be considered an activity in the course of employment if travel is part of the worker's duties or if the accident occurs on the employer's property or on a "captive road" provided and controlled by the employer, such as logging roads used by forestry workers.

If serious and willful misconduct on the part of the worker is the sole cause of the injury, no compensation is paid unless death or severe disability results.

h) Secondary Conditions

Where the worker suffers consequences from the injury, in addition to the injury, these may be "compensable consequences". Some common compensable consequences of injury include chronic pain and the development of psychological conditions after the initial injury (unless they arise due to the WCB process).

The test for whether a secondary condition is compensable is one of **"causative significance"**. According to well-established jurisprudence, this means that the initial injury does not have to be the sole cause or even the dominant cause of a secondary condition; it must be only of causative significance greater than being trivial or *de minimis*: *Chima v. Workers' Compensation Appeal Tribunal,* 2009 BCSC 1574, *Schulmeister v. British Columbia (Workers' Compensation Appeal Tribunal),* 2007 BCSC 1580, and *Albert v. British Columbia (Workers' Compensation Appeal Tribunal),* 2006 BCSC 838.

As discussed above, if the worker suffered from a pre-existing condition and the injury aggravates, accelerates or activates this condition, the resulting aggravation may also be compensable. (NOTE: this policy is complex and should be consulted for specific details)

The *Kovach* decision (supra) upheld the Board's policy that a worker who is undergoing treatment for a work injury remains in the course of employment, even if the treatment takes place long after the job itself has ended (even years after). This decision means that workers undergoing treatment for an injury or disease generally cannot sue negligent medical providers for medical malpractice.

V. OCCUPATIONAL DISEASES

A. *Overview of Compensable Occupational Diseases*

An Occupational Disease (OccD) is a particular disease or medical condition which is recognized by the Board as likely or possibly caused by work, based on scientific evidence. The Board "recognizes" an OccD formally by listing it in policy and these lists are updated as new scientific evidence becomes available. A "disease" is a broad category which includes exposures, cancer, poisons, repetitive strain injuries, hearing loss and contagious and respiratory diseases.

To determine if a worker's medical condition is a recognized OccD, consult the two policy provisions listing the recognized OccDs: **Appendix 2 (RSCM II)/Schedule B (WCA)**, which sets out OccDs recognized as qualifying for a presumption of work causation for certain industries, and **Policy #26.03** in Chapter 4 of the RSCM II, which sets out additional OccDs recognized by Regulation. Each type has different tests for work causation, which must be met if the OccD is to be accepted by the Board as compensable.

B. *Occupational Diseases listed in Schedule B (Appendix 2 of the RSCM II)*

OccDs listed in WCA Schedule B are matched with the particular industries in which they commonly occur. If the worker has that disease and works in the listed industry at the time of disablement, the OccD is presumed to have been caused by that work unless the contrary is proven [section 6(3) of the Act]. A presumption of work causation only arises for diseases mentioned in Schedule B when the worker is working in the listed industry immediately before the date of disablement. Otherwise, no presumption applies. Also, the contrary may be proven in an individual case. For example, where a worker was employed as a coal miner at or before the date of disablement, silicosis is compensable unless it is proven to have been caused by non-work factors such as smoking.

OccDs in Schedule B include certain kinds of cancers, respiratory diseases including asbestosis, and repetitive strain injuries. If a worker has a Schedule B disease but does not work in the listed industry, the worker's OccD can still be compensable if work causation can be proven under section 6(1). In addition, section 6.1 of the WCA sets out a special work presumption for firefighters who suffer a heart attack on the job.

Policy #26.21 of the RSCM II provides a helpful guide to the special rules for a Schedule B presumption.

C. *Occupational Diseases listed in policy #26.03 RSCM II*

Additional OccDs are listed in Policy #26.03, including many repetitive strain injuries and specific conditions such as plantar fasciitis and Lyme Disease. These diseases must be adjudicated under s. 6(1) of the WCA, where work causation must be proven in each case.

Section 6(1) states that if:

- a worker suffers from an occupational disease and is thereby disabled from earning full wages at the work at which he or she was employed; or
- the death of a worker is caused by an industrial disease; and
- the disease is due to the nature of any employment in which the worker was employed, whether under one or more employments; then:

compensation is payable as if the disease were a personal injury arising out of and in the course of that employment.

In addition to these statutory provisions, policy #26.20 sets out guidance for establishing work causation for OccDs in general, and policy #26.22 sets out the Onus of Proof for non-presumptive OccD causation. These policies can be helpful guidance when framing a submission on causation for a s. 6(1) OccD case.

There are also particular policies applying to particular conditions, organized by type of condition, which are usually referenced in decision letters involving those conditions.

Policies numbered #27 apply to particular repetitive strain injuries/activity-related soft tissue disorders (ASTDs). NOTE: most ASTDs can be injuries or diseases, and many are listed in Schedule B (i.e. may or may not qualify for the work presumption).

Policies #28 for Contagious Diseases (e.g. scabies)
Policies #29 for Respiratory Diseases (e.g. asthma, silicosis, asbestosis)
Policies #30 for Cancers
Policies #31 for Hearing Loss

D. *Special Issues for all OccD cases:*

Date of Disablement

For an OccD, **the first date of disablement is treated as the "date of injury"** for the purpose of calculating the one-year time period to submit a compensation application (s. 55, WCA). Special rules apply for OccD late applications and for Federal Workers. (see policy #32.)

Timely Application & Health Care

For diseases with a long latency period such as asbestosis and most cancers, a timely application may result in only receiving health care benefits at first. These healthcare benefits can include, for example, medical benefits, necessary adjustments to the residential home, and home-care.

Standard of Proof

Schedule B diseases and the diseases recognized by regulation (#26.22) have an "as likely as not" standard of proof for causation (s. 99, WCA). This means that where the evidence is equally weighted for different interpretations, the interpretation that favours the worker should be preferred. For example, *Fraser Health*, supra, upheld a WCAT decision that an unusually high rate of cancer in a group of lab technicians was an OccD and therefore compensable. Though experts had found little positive evidence supporting this link, the cancer rate in this group was highly unusual. Combined with the significant possibility of non-trivial exposure to harmful substances in the workplace, WCAT decided that was enough to satisfy the "as likely as not" standard.

Survivor Benefits

If a worker's disease causes death, the worker's spouse may be entitled to survivor benefits, even if the worker was not eligible for compensation.

NOTE: WorkSafeBC has developed the Exposure Registry Program, which is designed to be a forum for workers, employers or others to report work-related exposures. This registry is intended to track incidents of exposure to substances which are known to be harmful (such as asbestos), as well as exposures which may in the future be shown to cause disease (such as power line emissions). The information obtained through the registry will create a permanent record of a worker's exposure and will assist WorkSafeBC in establishing that the manifestation of a disease was due to the nature of the employment in which the worker was employed (a requirement under s. 6(1)(b) of the WCA). This will simplify the adjudication of future claims for occupational diseases caused by workplace exposure.

E. *Psychological Injuries*

A worker can claim for acceptance of diagnosed psychological conditions which arise as a consequence of physical injuries or OccDs which are accepted under s. 5 or s. 6 of the Act. Common psychological consequences include chronic pain and difficulties adjusting to a new disability. In practice, psychological limitations and restrictions can often be an overlooked aspect of an injured worker's reduced employability. However, they are important to recognize, diagnose and treat as this may be the difference between a successful rehabilitation and a failed one. When seeking acceptance of a psychological consequence of a compensable physical condition, the causal threshold is the same standard of "causative significance": Is the accepted physical injury a significant contributing cause of the psychological condition, meaning something more than a trivial or insignificant factor? If so, the

psychological consequence is compensable as well, including treatment. The physical injury does not need to be the sole or even most significant cause.

However, a worker may suffer a psychological injury alone, with no accompanying physical condition. Common examples include Post Traumatic Stress Disorder (PTSD) or Major Depressive Disorder (MDD). In such cases, the worker can claim for purely psychological injuries from their work under section 5.1 of the WCA and policy item #13.00.

Section 5.1 of the Act provides for two types of psychological injuries, each with a different causation test. A worker can claim for a psychological injury that is either:

a) A reaction to one or more traumatic events arising out of and in the course of employment; or

b) Predominantly caused by a significant work-related stressor, including bullying or harassment, or a cumulative series of such stressors, arising out of and in the course of employment.

A psychological injury which arises from a traumatic event must meet the usual causation test that employment was "as likely as not" the cause of the condition. However, a psychological injury which is caused by "stressors" (vs. "traumatic events") must meet the "predominant cause" standard. This is a significant hurdle for workers with pre-existing psychological conditions who become disabled after work stressors, such as bullying or harassment.

Section 5.1 also requires that a psychological condition be diagnosed as a mental disorder by a registered psychiatrist or psychologist. Section 5.1 also provides that mental stress arising from a decision by the worker's employer related to the employment (e.g. a change in job description or working conditions, or termination of employment) is specifically excluded from compensation. However, an employer may not communicate a management decision in any way it wants and communication that humiliates, intimidates, or amounts to bullying, harassment, threats or abuse may be beyond 5.1(1)(c) protection.

Psychological injuries that result from interaction with WCB and the claims process are also not compensable (Noteworthy Decision: WCAT-2015-01459). Though they would not happen but for the workplace injury they are too remote to be compensable. Exceptions may arise in special circumstances, e.g. where the Board has acted negligently, or in bad faith.

F. *Hearing Loss*

Significant hearing loss caused by exposure to industrial noise in the course of employment is compensable. The worker must submit tests showing the loss of hearing and complete a special application form listing all employment and non-employment noise exposure. See s. 7 and Schedule D of the WCA.

VI. CLAIM BENEFITS

A. *Benefits*

In a sense, BC has **two** Workers' Compensation Systems that work in tandem. One system pertains to injuries which occurred before June 30, 2002 and the other to injuries which occurred on or after June 30, 2002. The following section will discuss injuries that occurred on or after June 30, 2002. **If you or your client was injured prior to June 30, 2002, be aware that different rules apply.** Refer to the *Rehabilitation Services and Claims Manual* for more information. Volume I of the Manual applies to most injuries that occurred prior to June 30, 2002, while Volume II applies to injuries that occurred on or after June 30, 2002.

B. *Short Term and Long Term Wage Rates*

When a compensation claim is accepted, the Board sets the worker's wage rate at two different points in the claims process. All claims benefits (e.g. LOE, PFI, TWL) are paid according to these rates. If you or your client believe your benefits do accurately reflect your income before your injury, it is vital that you try to correct this as soon as possible.

At the beginning of the claim, the Board sets a short-term wage rate (STWR). After 10 weeks, if the worker is still on benefits, the Board sets a long-term wage rate (LTWR). Both the STWR and LTWR are set at 90% of net earnings but the calculation of these earnings are different (in most cases) for the two wage rates.

Except for "casual workers" (see below), a worker's STWR is based on his gross earnings at the time of the injury with deductions assumed to be 1.5 times the basic personal deduction allowed under the Income Tax Act, RSC 1985, c 1 (5th Supp.) for a single taxpayer, plus the standard EI and CPP contributions. This results in a STWR that equates to 90 percent of the worker's take home pay for a single worker. For workers who have several dependants or much lower actual tax deductions, this calculation results in a lower wage rate than if the Board had used actual figures. However, because the STWR is only set for the first 10 weeks of the claim and generally reflects their current wages, many workers do not dispute this issue or appeal the STWR decision.

The determination of a STWR for "casual workers" is different. The WCA requires that where WCB determines that a worker's pattern of employment at the time of injury was "casual in nature", that the STWR be based on that worker's earnings over the immediately preceding 12 months of employment. The result is that a "casual worker" who is earning a good wage at the time of the accident will likely be eligible for less compensation during the initial payment period than his or her counterpart in a "permanent" job. Where the "casual worker" designation has been made in the STWR decision but is not correct, this may be an important appeal issue.

NOTE: Practice Directive #C9-9 currently describes a two-step investigation procedure to determine whether a worker's pattern of employment is casual in nature. If the job at the time of injury is scheduled to last for three months or longer, the worker will not be considered a casual worker. If the job is scheduled to last for less than three months, the worker may be considered a casual worker if he or she has a history of short term jobs (less than three months in length) with significant absences from employment between them (greater than the time spent employed). However, as PDs are updated and changed on a regular basis, the electronic version should be consulted.

The LTWR is based on a calculation of a worker's "average earnings" in the previous year and the worker's actual deductions. A worker's "average earnings" is a somewhat complex and careful calculation, subject to changing law and policy.

NOTE: Chapter 9 of the Rehabilitation Services and Claims Manual, Volume II (RSCM II) is entirely on "Average Earnings" and there are about 10 Practice Directives on these calculations. Rather than summarize this complexity, it is best to recognize that the Board's LTWR decision is based on an "average earnings" decision and that the "average earnings" decision is important to review on its particular facts.

Once the LTWR is set, the Board uses this LTWR figure to calculate the amount of any awarded WCB benefits, including pensions, on that worker's claim, for the life of the claim, except in the case of "re-openings" (see below).

Finally, for ongoing benefits, such as pensions, while the initial amount is determined on the basis of the LTWR, the benefit itself is adjusted annually according to inflation, at a rate 1 percent less than the actual inflation rate with a 4 percent cap on inflation adjustments, regardless of whether the actual inflation rate is higher. This applies to all workers, including those injured before June 30, 2002.

Recurrence or Deterioration and Wage Rates

A claim may be "re-opened" if a worker suffers a new period of temporary disability and/or an increased degree of permanent disability from a recurrence or deterioration of a previously accepted condition.

Under s. 35.1(8) of the current Act, a **recurrence** of an injury is treated as a new injury for any new period of temporary disability. In addition, if the re-opening is more than 3 years after the initial injury, the Board may reset the LTWR for the purpose of calculating additional benefits under the re-opening.

The applicable policy on re-setting LTWR for re-openings over 3 years is Policy #70.20. This policy is complex and it is best to consult this policy in light of the particular facts of each case. This policy affects all workers with long-term disabilities, where their condition recurs or deteriorates.

The re-opening provisions also have particular significance if the worker was injured prior to June 30, 2002, where the LTWR was calculated as 75% of gross and the definition of "average earnings" was different. For this worker, his re-opening TWL benefits would be calculated under the new policy provisions (90% of net average earnings).

It should be noted that a "recurrence" must be distinguished from a "**deterioration**". In *Cowburn v Worker's Compensation Board of British Columbia*, 2006 BCSC 722, the court found that it was patently unreasonable to treat a deterioration in a worker's disability as a recurrence of an injury. Accordingly, when a worker's permanent disability that began before June 30, 2002 becomes worse, the increased benefits are based on the older provisions that were in force when the disability first arose (such as pension entitlement). However, a new applicable wage rate may still have to be determined under policy #70.20.

C. *Average Earnings*

As noted above, the Board determines a worker's LTWR based on its calculation of his annual "average earnings" and because of this, "average earnings" is an important decision on the worker's claim.

In general, "average earnings" is set as the worker's employment income over the one-year period before the injury. Section 33 of the Act provides that the Board must use the exact previous one-year earnings unless the worker meets one of the few exceptions set out in the Act. If a worker has regular earnings in this one-year period before his injury, this is not difficult. However, if a worker has irregular earnings in this period (for any reason), it is important to consider whether his employment falls within one of the statutory exceptions; if not, it will be difficult for that worker to get a LTWR comparable to his actual earnings at the time of injury.

One exception is for "casual workers'. As noted above, "casual workers" already have their "average earnings" (over the previous year) calculated at the outset of the claim and for these workers, their STWR will be the same as their LTWR; both wage rates are likely significantly lower than the worker's actual wages at the time of injury. This section is rigidly applied.

Another exception is a "new" worker, defined as where the worker was permanently employed by the accident employer for less than 12 months before the injury. For this type of worker, section 33.3 of the WCA allows the "average earnings" to be calculated based on what a person of similar status employed in the same type and classification of employment would earn in 12 months. However, section 33.3 is not applicable where the worker's employment is deemed casual or temporary.

Under section 33.4 of the Act, the Board may also determine average earnings differently in "exceptional" circumstances, if the one-year average would be "inequitable". This provision does not apply to cases of "casual" workers or to "new" permanent workers as described above. Practice

Directive #C9-12 states that an exceptional case is one that is "truly extraordinary", "unusual", or "irregular", such that "the worker's circumstances in the year prior to the injury fail to provide any meaningful measure of their employment history". Examples might include a non-compensable illness or injury, or maternity/paternity obligations. Under this exception, an officer has discretion to seek a long-term average earnings figure that better reflects the worker's real income loss, possibly by excluding a significant atypical disruption (i.e. one lasting more than six weeks) or basing the worker's "average earnings" on a longer or shorter period of time.

Under WCA s. 33(3.2), EI benefits are included in the calculation of the worker's earnings for the year if the worker was, in the Board's opinion, employed in "an occupation or industry that results in recurring seasonal or recurring temporary interruptions of work". For a seasonal worker, this is an important distinction as can be seen by the example of a worker injured at work in his first week, after returning from a six month layoff. If this worker is designated as a "casual worker", the Board would simply calculate his earnings over the last year (including the period of the long layoff but without counting EI payments) to arrive at the "average earnings" over the one-year period before the injury. This figure would set both his STWR and LTWR and the only argument for a higher rate would be through section 33.4 of the Act. However, if the worker is found to be in a "highly seasonal" occupation, his EI benefits would add to the calculations of his "average earnings" and greatly increase his LTWR. In addition, his STWR (for the first 10 weeks) would be set in the usual manner as being his wages at the time of injury.

Where a worker has two jobs and is unable to work at either due to an injury at one, the worker's benefits will be calculated based on his or her combined earnings at both jobs, up to the statutory maximum. This applies even if the worker's other job is not otherwise protected by the WCA (Policy #65-02).

D. *Temporary Wage Loss Benefits (TWL)*

The WCA does not define "disability" although it uses this term throughout the Act. Section 29(1) of the Act states that if a worker has a temporary total disability (TTD), the Board must pay full TWL benefits (calculated according to the steps above), also referred to as "s. 29 benefits". Section 30 states that if a worker has a temporary partial disability (TPD), the Board must pay the difference between the worker's average net earnings before the injury and either their average net earnings after the injury OR the average net earnings in some deemed "suitable" occupation. These are referred to as "s. 30 benefits".

If a worker has an injury but can perform the full duties of the pre-injury job, the claim is accepted for health care benefits only (see below). If the injury is such that the worker cannot perform full duties, the Board makes an entitlement decision on an accepted claim regarding additional benefits, especially wage loss (#34.10). For most claims, the Board finds that there is some type of temporary disability:

TTD - worker not working at all: TWL paid under s. 29 of the Act;

TPD – worker working part-time work at a suitable occupation or deemed suitable occupation and paid Partial Wage Loss (PWL) under s. 30 of the Act; OR

Temporary Disability (of any kind) but the employer gives the worker suitable light duties as per policy #34.11. In this case, the Board usually does not pay the worker any TWL but the worker's other benefit entitlement (such as health care) is adjudicated under s. 30 of the Act. Policy #34.11 applies to any adjudication of these light duties, including where the worker refuses light duties on the grounds that they are unreasonable.

NOTE: Light duties is meant to be a temporary arrangement during a period of temporary disability. Even though no TWL is paid to a worker, it is still an accepted period of "disability" under the Act. During this period, a worker is entitled not only to health care benefits but also to a decision regarding the outcome of the accepted condition. All periods of "light duty" should conclude with a formal "resolve" or "plateau" decision (see below).

A temporary disability ceases when the worker's medical condition either resolves entirely or is not expected to change significantly in the next 12 months. At this point, the medical condition is said to have "plateaued" and is considered permanent. In either case, the Board ceases to pay further TWL under s. 29 or s. 30 at this point.

E. *Health Care Benefits*

Health care benefits are payable under s. 21 of the Act for the period of the worker's disability, and thereafter to "cure and relieve from the effects of the injury or alleviate those effects". Chapter 10 of the RSCM II greatly expands the Board's regulation and control of particular health care benefits including all forms of treatment, medical investigation with specialists, medical aids and medications. As noted above, if a worker has an impairment but can perform their full pre-injury job, the claim is accepted for health care benefits only (as long as there is a short episode of disability: policy #34.10).

There is now a general Board practice to not provide injured workers with medical treatment (such as physiotherapy or counselling) past the "resolve/plateau" point. This may be an issue for workers who are able to RTW with permanent injuries, especially in accommodated positions. Such worker may be suffering from the effects of their injury but are not considered "disabled". Likely they are entitled to on-going treatment under s. 21 of the Act but it may require an appeal to obtain such benefits.

The Board must pay for necessary medical treatment, including physicians and hospital bills, physiotherapy, drugs, artificial limbs, hearing aids, and special transportation. Allowances for personal care and for structural alterations to the home may also be paid to paraplegics and other severely disabled workers.

The Board has the right to supervise a worker's treatment (s. 21) and to authorize any surgery. If a worker decides to undergo surgery or other treatment that is not authorized by the Board, the costs may not be paid, and if the injury is worsened by the treatment, benefits may be cut off or reduced. The Board usually agrees to pay for surgery recommended by the worker's own doctor, but the doctor should ask for the Board Advisor's approval. The Board often refuses to pay for drugs or physiotherapy considered unnecessary by its advisors. Notwithstanding the 75-day time limit on Board reconsideration (WCA section 96(5)), the Board now agrees that each Medical Aid decision can be appealed.

F. *Income Continuity Benefits*

Although classified as VR benefits (described below), income continuity benefits are payments to provide interim support for the worker after TWL is terminated at plateau but before the amount of a permanent disability pension is determined. A worker's advocate should always request these benefits as they are often the only source of income that a worker will have between the time the worker's condition stabilizes and the time the pension benefits are assessed. These are short-term, temporary benefits.

If a worker refuses employment or to participate in a Board issued VR plan, he or she may be refused income-continuity benefits. See Policy C11-89.10 of the RCSM for more information regarding the assessment of income continuity benefits.

G. *Vocational Rehabilitation Benefits*

The Board usually assesses whether a worker needs assistance to return to work (RTW) at or near the end of his or her temporary disability. If the worker has a permanent impairment and is not able to safely RTW without assistance, he or she is referred to Vocational Rehabilitation (VR).

If a worker is struggling or unsafe near the end of the period of wage loss, an advocate should review the file to ensure a referral to VR is made. If there is no referral, the advocate may make a direct request to the CM and/or appeal the "resolve" or "plateau" decision on the basis that these decisions

do not contain a VR referral, when one is needed. Policy #85.00 and #86.00 set out the principles, goals, and eligibility criteria for VR benefits.

Once a VR referral is made, the Board may provide a large variety of VR services to injured workers. These are discretionary benefits under s. 16 of the Act, governed by the policy set out in Chapter 11 of the RSCM II. Generally, the extent of VR services generally depends on the nature of the worker's disability.

The policy requires that the assigned Vocational Rehabilitation Consultant (VRC) consult with the worker and issue a written VR plan identifying a suitable occupational goal and the VR services required. In identifying a suitable VR plan, the VRC works through five VR phases, set out in Policies C11-85.00 to 91.00. In fatal cases, a surviving spouse may be eligible for retraining.

In brief, the phases are:

1. Phase One: The VRC will make an effort to assist the worker to return to the same job with the same employer (the "accident employer"). This may require some phased in work programs such as a gradual RTW or work conditioning.

2. Phase Two: If the worker cannot return to the same job, the VRC works with the accident employer to make worksite accommodations and job modification, or to provide alternative in-service placement, with a view to finding the worker a new position within the accident employer's business.

3. Phase Three: If the employer is unable or unwilling to accommodate the worker, the VRC identifies suitable occupational options in the same or related industry. This may require the worker to obtain additional skills or training or to be supported in periods of job search.

4. Phase Four: If the worker is unable to return to employment in the same or related industry, the VRC explores opportunities in all industries, with emphasis placed on the worker's transferable skills, aptitudes and interests.

5. Phase Five: If the worker's existing skills are insufficient, the VRC may utilize additional training programs to help the worker acquire new skills and may also assist the worker in a job search once training is complete.

The particular VR benefits which are authorized for the worker are be spelled out in detail in the formal VR plan, which should be provided to the worker. The worker's VR plan is first published as a document, discussed with the worker, and then is set out in a formal appealable decision.

VR services can include:

- monthly compensation (in the same amount as wage loss benefits) to support a worker during a rehabilitation program;

- payment of tuition, books, and other costs of the course itself;

- employability assessments

- a job search allowance (also in the same amount as wage loss benefits) to support the worker while looking for suitable employment if he or she cannot return to the pre-injury job; and

- a training on the job allowance or wage subsidy to encourage an employer to allow the worker to learn new employment skills, or gain experience in a new field.

In practice, the Board will only issue one VR plan and ask the worker to agree to it. The plan must be reasonable. If the worker thinks a VR plan is not reasonable, they should appeal the VR decision setting out the VR plan and ask for a new plan, being as specific as possible as to why the VR plan is unreasonable, and if possible, what a reasonable VR plan may be.

If a worker is cooperating with VR re-training, they should continue to receive benefits at the full wage loss rate. If a worker is appealing a VR plan as unreasonable, the worker may wish to keep cooperating with the challenged VR plan during the appeal period in order to continue receiving benefits.

VR benefits, under a formal VR plan, may be terminated for reasons set out in Policy #88.00. These reasons include if the worker is not cooperating or if he withdraws for personal reasons or refuses suitable employment or is prevented from participating by non-compensable factors alone. If the worker believes that the Board's reasons for terminating VR benefits are inaccurate or wrong, the termination decision should be appealed. This is particularly important if the worker is failing in VR due to some aspect of his medical condition.

At the end of the VR process, the VRC issues a decision about the worker's future earning capacity in a suitable occupation and whether VR has restored it to near its pre-injury level. Based on this final VR decision, the Board then determines whether the worker should be considered for a loss of earnings (LOE) pension.

Rehabilitation decisions can be reviewed only by the WCB's Review Division; the RD decisions on VR cannot be appealed to the Workers' Compensation Appeal Tribunal.

While the Board routinely relies on the VRC's decision regarding the worker's employability, WCAT does not consider these VR decisions as binding on them when adjudicating an LOE pension issue on appeal. EXAMPLE: A VRC finds that a worker can adapt to working full-time in a particular occupation, when he cannot. The worker may still raise this issue and provide evidence about disability in his appeal of a denial of an LOE pension, both at the Review Division and WCAT.

NOTE: Many difficulties in this area arise from different concepts of disability and employability. The Board tends to assess a worker's permanent disability in terms of impairment and to limit its assessment of impairment to "medical restrictions and limitations" (R&Ls) i.e. specific activities which the worker cannot do or should not do at all because of potential harm. R&Ls may or may not include other aspects of limited ability such as tolerance or endurance (such as an inability to sit for more than 10 minutes) which are key elements of work function. Also, disabled workers often face discrimination and other barriers to employment. Court decisions have been clear that VR processes must address the whole worker, including any pre-existing disabilities or factors affecting employment (*Young v. WCAT* 2011 BCSC 1209) but this remains a contentious area and one that the Board does not consider part of the "compensable" condition.

H. *Permanent Disability Pensions*

Once a worker's condition has stabilized or "plateaued", i.e. is not likely to get significantly better or worse in the next 12 months, TWL benefits will cease. If the worker continues to have some disability, they will be assessed for a permanent disability pension. A disability pension is possible if WCB determines that the worker has been left with a permanent disability.

A case manager will determine which conditions or injuries are permanent and refer the worker for assessment. Decisions not to refer a worker at all or to exclude certain injuries or conditions are appealable to the Review Division and, if necessary, WCAT.

A WCB "pension" is how the Board compensates an injured worker for a permanent disability. There are two possible methods for calculating a pension – compensation for permanent functional impairment (PFI) or compensation for loss of earnings (LOE).

All permanent disability pensions are paid until age 65, unless the worker can convince the WCB otherwise (discussed in detail below).

NOTE: Workers who also qualify for Canadian Pension Plan (CPP) disability benefits will have one-half of those benefits deducted from their WCB pensions (this could amount to as much as $577 per month, half of the $1153 maximum currently payable by CPP). This deduction represents the employer's share of the benefits paid for the same disability as the WCB claim. If a CPP pension is partly based on non-compensable disabilities, no deduction will be made for that portion of the CPP.

Functional Impairment Method

The first calculation for permanent partial disability pensions (called "Permanent Functional Impairment") compares the worker's degree of physical impairment to that of a totally disabled person. The percentage of impairment is usually based on the RSCM's Permanent Disability Evaluation Schedule (PDES).

Generally, only disabilities that could reduce earning capacity receive compensation, and there are no payments for pain and suffering or loss of enjoyment of life. The Board's policy manual contains detailed schedules of percentage disability for different types of disabilities. Types not listed are estimated, and there is usually some degree of discretion in the process.

Policy item #39.10 says that the PDES is meant to be a guideline and not a rigid formula. The WCB is free to apply other variables in arriving at a final award, but they must relate to degree of impairment and not social or economic factors, or rules established in other jurisdictions. In practice, the PDES is applied with little discretion.

Note that loss of function awards for chronic pain are capped at 2.5% per area of pain.

Projected Loss of Earnings Method

This second calculation for permanent partial disability pensions compares the long-term wage rate that a worker was able to earn per year before the injury to what the worker is able to earn after the injury, based on occupations that are suitable for and reasonably available to that worker.

Loss of earnings pensions will only be paid where the amount determined under the loss of function method would leave the worker with a significant loss of earnings, i.e. where 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 (See WCA s 23(3.1) and Item #40.00 in the RSCM). Practice Directive #C6-2 further defines "significant loss of earnings". A 25% or greater percentage differential between pre-injury and post-injury earnings is usually considered significant. A 5% or less percentage differential is not considered significant. Anything in between could be considered significant, depending on the individual circumstances of the case. Note that the Practice Directive is not binding law, but is still persuasive.

Where workers are unable to replace their pre-injury earnings, the WCB often "deems" them capable of earning significantly more post-injury than they actually are earning or can earn following an injury. For example, a worker who cannot return to a pre-injury job that paid $4000 per month may find new employment for $2000 per month. Instead of accepting the worker's own experience, the Board may decide that over the long term the worker can find a different kind of job that pays $3000 per month, and calculate the benefits accordingly. Instead of getting a loss of earnings pension representing the actual $2000 per month the worker is

losing, he or she would receive a pension based on the $1000 the Board "deems" him or her to be losing. Common problems workers face in these situations are that the Board may underestimate the actual extent of physical or psychological limitations they have due to their injury and/or pre-injury background, underestimate the demands of the deemed occupations the Board says they can perform, and/or overestimate what they are actually capable of earning over the long term in the deemed occupations, therein deeming them capable of theoretical earnings that far exceed what is reasonably suitable for and available to them. On appeal of a loss of earnings decision (and often a VR rehabilitation plan decision), the worker should provide evidence to counter these common problems.

Given the above, the vast majority of workers will only receive a Permanent Functional Impairment (PFI) award for their **permanent partial disability.** For exceptional cases where the PFI award is inadequate, an additional Loss of Earnings (LOE) award will be provided. In cases of severe disability, a worker may have a **permanent total disability** equal to 100% PFI. In these cases, the WCB will pay the worker a monthly payment equivalent to a 100% LOE pension. Some examples of permanent total disability are paraplegia, quadriplegia and total or near blindness.

I. *Benefits after Age 65*

Policy item #41.00 states that payments for permanent disability pensions end at age 65 unless the WCB is satisfied that the worker would have retired at a later date. The worker is asked to provide independent verifiable evidence at the time of the permanent disability award (or on appeal) that he or she had plans prior to injury to work beyond age 65. This type of evidence can often be unavailable. A series of WCAT and RD decisions have held that if independent verifiable evidence is not available, the available evidence including workers' statements should be considered to determine whether the worker had plans prior to the work injury (or in some cases prior to the time of the permanent disability award). See WCAT-2014-00467, identified as "noteworthy" on the WCAT website; if for example the worker had sincere plans to continue working past age 65 due to some combination of emotional and financial need, this may be sufficient to extend the pension.

J. *Benefits in Fatality Cases*

For deaths that occurred on or after June 30, 2003, the following rules apply. Different rules may apply to deaths that occurred prior to June 30, 2003.

A child eligible for compensation includes a child under 19 years of age, an invalid child of any age, and a child under 25 years of age who attends a school.

Spousal benefits are not lost upon re-marriage, and survivors' pensions are not terminated when the worker would have reached age 65 (s. 19.1). In older cases, a spouse of a deceased worker who remarried might have lost their benefits. Under the new legislation, there are no such exclusions. Instead, s. 19(2) states that a person whose payments were discontinued under a former section is entitled to complete payment of all benefits that he or she would have been entitled to – as though the section had not applied.

Where death results from a compensable injury or industrial disease, the surviving dependents may receive lump-sum payments or monthly pensions based on the deceased worker's earnings. These pensions cannot exceed the statutory maximum, and are adjusted in accordance with changes in the Consumer Price Index. The amount of the pension for spouses without dependent children depends on the surviving spouse's age (s. 17(3)(d)).

A separated spouse may receive benefits based on the amount of support the deceased worker would likely have contributed had he or she survived (s. 17(9)). A common law spouse is entitled to benefits after three years of cohabitation or after one year if there are children. However, compensation may not be paid, or may be reduced, if there is a separated spouse as well.

K. *Suspension of Benefits*

Benefits may be suspended:

a) if a worker persists in unsanitary or injurious practices, which tend to **prevent or slow recovery**;

b) if a worker refuses to submit to medical or surgical treatment, which, in the opinion of the WCB, is **reasonably essential** in promoting recovery;

c) if a worker fails to attend a medical examination arranged by the Board; or

d) if a worker is in prison, in which case benefits will cease, or be paid to his or her dependants.

The Board may also divert compensation from a worker for the benefit of his or her dependants if the worker is not supporting them.

Under s. 57.1 of the WCA, the Board may withhold or reduce benefits for any period the worker does not provide requested information (unless the Board finds that it was unclear in communicating the requirement, or erroneously concluded that the worker was being uncooperative). However, such benefits will be paid when the worker provides the necessary information.

L. *Emergency Assistance*

Many workers need immediate income if they are waiting to be accepted or their benefits have been disallowed or terminated. They should consider alternate sources: social assistance, which may provide a crisis grant for immediate temporary relief or longer term relief if a decision is being appealed, EI sickness benefits, CPP disability pensions, any plans available through their place of work or union, ICBC (if an automobile was involved), or private disability insurance.

M. *"Resolved/Plateau" Decision Letters*

There are other key decisions in a worker's claim including the initial decision to accept or deny a claim and any VR or pension decision. However, it is important to note the decision which is issued at the end of a period of temporary disability. This decision, referred to as a "resolved/plateau" decision, usually embeds several key decisions, each of which may be appealed.

Briefly, the decisions usually embedded in the "resolve/plateau" decision include:

Has the Worker's Injury/OccD Stabilized?

The first key issue is an accurate medical assessment of the worker's compensable condition at the critical point of a "resolve/plateau" decision. As noted above, if a work injury or OccD has resolved entirely, the Board issues a "resolve" decision and the claim file is closed. If the injury has only stabilized, then the Board issues (or should issue) a "plateau" decision. If the injury has not yet stabilized, the Board should continue to treat it as a temporary disability with temporary benefits (WL and/or health care benefits).

An appealable matter arises if the Board issues a "resolve" decision but the worker or the medical evidence indicates that there are ongoing effects, conditions or impairments from the injury (e.g. chronic pain). In this case, both the medical evidence and the Board's adjudication should be assessed. The medical evidence should be assessed to determine if the compensable conditions are still temporarily disabling (i.e. the worker is not able to fully return to pre-injury work) so that the worker continues to be entitled to temporary ongoing benefits, or if the compensable conditions have reached a "plateau" as defined by policy #34.35 and the worker is entitled to a referral to Disability Awards and (sometimes) Vocational Rehabilitation (VR).

The issue of "fully resolved" vs. plateau is a medical issue. "Fully resolved" means that there is no permanent or ongoing residue or impairment from the injury. If the claim is concluded on the basis that the compensable condition has "fully resolved", then no further benefits flow and it will be very difficult to reopen the claim later. If the injury is not fully resolved medically, the file should not be closed. Just because a worker returns to pre-injury employment (no disability so no WL) does not mean that the injury is "fully resolved"; the injury may have stabilized into a permanent impairment which is not disabling. If the worker is issued a "resolve" letter and there are ongoing medical issues or symptoms, the "resolve" decision should be appealed.

If the condition has not resolved but you are unsure whether it is still a temporary or permanent disability, policy #34.54 gives the criteria for making a determination between temporary and permanent conditions in this context. Basically, the policy states that a medical condition is "stabilized" when there is little potential for improvement or where any changes are in keeping with the normal fluctuations for that condition. Most doctors know the term "plateau" in this sense and the worker's GP may well address this matter in the last report on the claim file (found in the medical section).

Plateau Date

If the worker has plateaued, there should be a particular date identified in the decision letter as being the date of "stabilizing" or "maximum medical recovery" (MMR) or "plateau". You can assess whether this date is appropriate, considering:

a) Have all the compensable conditions been considered? And

b) Is it appropriate given the criteria in policy #34.54 and the medical evidence?

EXAMPLE: If further treatment (physiotherapy or surgery) is likely to make a significant change in the worker's condition within three months, then the condition should continue to be temporarily disabling and the worker should get TWL until then.

What Permanent Conditions are Accepted and what Conditions are Denied?

In the plateau decision letter, the CM sets out which exact conditions are accepted as permanent. These permanent conditions may be somewhat different than those originally accepted on the claim. For example, if a worker falls and suffers multiple injuries, some of the injuries are likely to fully resolve (sprains) while others can potentially leave a residual impairment (broken leg which mostly heals but leaves the worker with a limp). Other injuries will leave a very significant permanent impairment (mild brain injury). It is also possible that the worker has developed additional conditions during the temporary period (infections, psychological conditions, chronic pain, addiction, etc.).

Typically, as a worker nears plateau, the CM refers the claim to a Board Medical Advisor (BMA) to assess whether the worker has reached plateau, and to determine the likely plateau date and what permanent conditions should (and should not) be accepted on the claim. The BMA assessment may or may not be explicitly referenced in the plateau decision. The complete BMA opinion can be found as a "Clinical Opinion" in the Medical section of the claim file.

a) Accepted and Denied Conditions

It is **very** important to carefully assess which conditions are accepted and denied as permanent on the claim as these conditions will likely govern all future benefits. All plateau decisions should include a referral to Disability Awards (DA) for assessment of the permanent disability.

The plateau decision may also set out why certain medical conditions are denied as compensable permanent conditions. For example, if the Board finds that the identified conditions have resolved and the worker disagrees, this is a very important appeal. Sometimes the medical evidence on the claim file is sufficient to establish that the condition has not resolved; if not, the worker will likely need additional medical evidence.

Another common reason for denying permanent conditions is that the Board considers that the conditions pre-existed the injury and were not permanently aggravated by the injury, even if there was a temporary aggravation. There are two distinct types of pre-existing conditions:

The pre-existing condition or disease was **non-deteriorating**:

As set out in policy #16.00 (Chapter 3) for injury and policy #26.55 (Chapter 4) for OccD, if the post-plateau condition is not significantly worse than before the injury, then the condition was not permanently aggravated by the work injury/OccD. This is an issue for which medical records are important; or

The pre-existing condition or disease was **deteriorating:**

If the worker had a pre-existing deteriorating condition, the test is whether the work injury "significantly accelerated, activated or advanced" the condition more quickly than would have occurred in the absence of the work injury (policy #16.00). The Board commonly denies permanent disability on the basis that it arises from a natural degeneration of a pre-existing condition such as degenerative disc disease or osteoarthritis.

b) Missing Conditions

The plateau decision (accepted and denied conditions) may not fully encompass the medical conditions which are noted by the worker or by the medical practitioners. This is best seen by comparing the decision letter with the medical evidence. If the decision is silent on a medical condition, you can ask for a new or additional decision from a case manager. Alternatively, if you are appealing the plateau decision on other grounds, in the appeal you can ask for a remedy that additional conditions be accepted on the claim.

Can the Worker Return to the Pre-Injury Job? (not appealable)

A case manager's decision that a worker can return to their pre-injury job is considered to be a finding of fact and not an appealable decision. In the context of a plateau decision, this RTW finding means that the Board considers that the accepted permanent conditions do not impair or disable the worker from their pre-injury job.

If this is not the case, this is a very important issue to challenge. Since an appeal of a plateau decision often involves seeking additional TWL, a new plateau date, additional permanent conditions, etc., the RTW finding of fact can be addressed in the context of these additional issues.

However, if there are no other issues in the plateau decision except this RTW finding, the plateau decision should be appealed on the grounds that the worker cannot to his pre-injury job and is entitled to additional VR benefits. Framing the appeal issue in this way ensures that the RD has an entitlement decision to address.

If Not, Referral to Vocational Rehabilitation (VR)

If the Board finds that the worker cannot return to his pre-injury job, then the case manager will most often refer the case to VR for VR benefits.

Did the Worker Suffer an Exceptional Loss of Earnings?

There is a varied Board practice on whether the plateau letter will contain a decision on a worker's entitlement to a Loss of Earnings (LOE) assessment or whether this decision will be deferred, pending the outcome of VR. However, all plateau letters should be assessed for whether they contain an LOE decision (express or implied) and if so, if this decision should be appealed.

VII. APPEALS

For most issues, the first level of appeal is to the Review Division of the WCB. Certain issues may undergo a second level of appeal to the Workers' Compensation Appeal Tribunal (WCAT).

Section 96(4) does allow the Board to "reconsider" **any** past decision, on its own initiative, but s. 96(5) prohibits it from doing so if a decision is more than **75 days old** unless there has been fraud or misrepresentation (such as when a videotape may show that the worker is less disabled than claimed). The Board interprets this to mean that the reconsideration **must be completed**, not just initiated, by the 75th day, and staff have been advised that they cannot correct even an error of law after that time, or change a decision to give effect to persuasive new medical evidence not available when the original decision was made.

A. *Internal Review - Workers' Compensation Review Division*

A worker, a deceased worker's dependant, or an employer may request a review of any of the following decisions of the Board:

- a decision respecting a compensation or rehabilitation matter (e.g. denial of benefits, or quantum of benefits);

- a decision levying payment by the employer for failure to comply with the statute; or

- a decision respecting an occupational health or safety matter.

The Review Division may also reconsider its own decisions in some cases. It can only undertake such a reconsideration during the first **23 days** after the decision is made, and only if no appeal has yet been filed to the WCAT. The Internal Review Division's powers are slightly greater than the Board's – it can change a decision on the basis of new evidence that didn't exist or couldn't have been presented previously with "due diligence" on the part of the applicant. Even that authority, however, ends on the 24th day. This means that for decisions that cannot be appealed to the WCAT, like vocational rehabilitation issues and many pension amounts, there will be no way for anyone in the system to change an incorrect decision based on new evidence, even if it could not possibly have been presented earlier and shows conclusively that the decision was wrong.

B. *Appeal to Workers' Compensation Appeal Tribunal (WCAT)*

A worker, a deceased worker's dependant, or an employer may appeal most decisions of the Review Division to WCAT. The following classes of decisions may **not** be appealed to WCAT (s. 239 and *Workers Compensation Act Appeal Regulations*, BC Reg 321/2002):

- decisions respecting vocational rehabilitation (s. 16);

- amount of a functional pension if the possible range is 5% or less, and commuting a pension into a lump sum payment (ss. 23 and 35);

- decisions applying procedural time limits specified by the Board under s. 96(8) of the Act;

- decisions refusing to allow an extension of time to file a request for review (s. 96.2 (4));

- decisions relating to the conduct and procedural policies implemented by the Review Division for the internal review (ss. 96.4(2) to (5) and 96.4(7));

- orders by the chief review officer as to whether or not to suspend the operation of a decision pending completion of the review (s. 96.2(5));

- decisions about whether or not to refer a decision back to the Board following completion of the Review Division hearing (s. 96.4(8)(b)); or

- decisions respecting the conduct of a review in respect of any matter that cannot be appealed to WCAT under s. 239(2)(b) - (e) of the Act.

As an administrative Tribunal, WCAT is subject to the expectations of procedural fairness common to all such bodies (i.e. appellant's right to be heard, right to a decision from an unbiased decision maker, right to a decision from the person who hears the case, and a right to reasons for the decision). As an independent body, WCAT is not bound by any WCB findings and has exclusive jurisdiction to make any findings of fact it deems relevant to the appeal (WCA s. 254 as interpreted in *Preast v. Workers' Compensation Appeal Tribunal*, 2015 BCCA 377). Additionally, WCAT is not bound by its own previous decisions unless departing from them is clearly irrational (*Macrae v. Workers' Compensation Appeal Tribunal*, 2016 BCSC 133).

WCAT's *Manual of Rules of Practice and Procedure* (MRPP) is accessible online at www.wcat.bc.ca as are appeal forms, guidelines and information about filing appeals.

C. *Access to Files*

Under the *Freedom of Information and Protection of Privacy Act*, RSBC 1996, c 165 (FIPPA), all workers have the right to receive a copy of their file. Employers have the right to obtain a copy of the Board's file if an appeal is pending or if a decision is made. The Act, however, limits an employer's ability to use this information in non-employment related issues. An employer, for example, may not use the information contained in the worker's file for disciplinary purposes.

A worker's WCB claim file that is disclosed for purposes of an appeal or a Freedom of Information request should contain all of the information pertaining to the Board's decision, as well as copies of any decisions regarding the claim.

Prior to May 2009, a file was divided into various sections such as: Claims, Medical, Accounts, and Memo. Usually the papers were filed in chronological order. Files are organized differently under the CMS data management system. Now, the preferred method of disclosure is by way of an encrypted .pdf file on a CD. The first disclosure will be a complete copy of the file, not just an update.

Overall, the adoption of electronic (E-file) rather than paper files has reduced administrative delays due to files being in use by other departments at the WCB or WCAT, but it has also decreased the detailed information explaining how decisions were reached, as handwritten notes and other documents are sometimes omitted. A request for disclosure under the FIPPA usually results in a more thorough search for such records, and is advisable in cases where all information is needed. At times, the Board may not disclose all of the relevant evidence in its possession. One reason is that certain departments at the Board, such as the Vocational Rehabilitation Department, keep unofficial sub-files or documents in draft form, which may not be fully incorporated into the worker's electronic "claim file". Some of the missing information may be helpful for appeals, such as the actual observations of the Board's staff during a functional evaluation, rather than just a final report.

D. *Appeal Procedure – Workers' Compensation Review Division*

A complete account of the review process goes beyond the scope of this chapter. A good starting point in preparing a review of the Board's decision is to go to www.worksafebc.com and look for the "Manage a Claim" section, under the "Claims" menu. Follow the link under the heading "If you disagree with a claim decision". There is a Policy and Procedures Manual that describes the process in detail, as well as provides the necessary forms and applications. Limitations as to what kinds of decisions can be appealed, and what persons can appeal them, are clearly stated within this section.

To request a review, the worker must complete and submit a two-page Request for Review form (available online). This form may be submitted by mail or by fax. See **Appendix D: Checklist for Review Division Appeals**.

E. *Appeal Procedure – Workers' Compensation Appeal Tribunal*

Similarly, the best starting point to prepare an appeal to the WCAT is to go to the website: www.wcat.bc.ca. The "How to Appeal" section provides information regarding the appeal process, enables access to various appeal forms, and provides internet links to WCAT publications as well as other resources that can assist in the appeal process. The WCAT site also contains a detailed manual. Parties applying for reconsideration must write to the Tribunal Counsel Office. WCAT will not accept applications for reconsideration by telephone. Note that WCAT can reimburse workers for the cost of acquiring medical reports that are reasonably useful to the hearing.

F. *Reconsideration of WCAT Decisions and Judicial Review*

WCAT decisions are "final and conclusive", but are subject to reconsideration based on statutory and common law grounds. If you are successful, the original decision will generally be found void, in whole or in part, and a WCAT panel will hear the appeal once again.

Section 256(3) of the WCA allows for a party to a completed appeal to apply for reconsideration of a decision based on evidence which:

- is substantial and material to the decision, and
- did not exist at the time of the appeal hearing or did exist at that time but was not discovered and could not through the exercise of reasonable diligence have been discovered.

If you apply for reconsideration based on new evidence, you must explain:

- why the new evidence is substantial (has weight and supports a different conclusion);
- how it is material (is relevant to the decision);
- whether or not the evidence previously existed; and
- if it did exist previously, why you did not discover (and submit) it at the time of the original hearing.

A claimant can only apply once for reconsideration on new evidence. They will not be able to re-apply multiple times for any new evidence that might become available in the future.

The first stage of reconsideration results in a formal written decision, issued by a WCAT panel, determining whether there are grounds for reconsideration. If the panel concludes that there are no grounds for reconsideration, WCAT will take no further action on the matter. If a panel decides that there are grounds for reconsideration, the original decision will then be found void (in whole or in part) and the application will proceed to the second stage at which a WCAT panel will hear the appeal once again. The WCAT will decide whether the second stage will be conducted by oral hearing or written submission.

WCAT has the authority to reconsider both WCAT and the former Appeal Division decisions. WCAT does not, however, have the authority to reconsider decisions by the former Review Board or the current Review Division. Objections to those decisions will be treated as appeals, or applications for extensions of time to appeal. Additionally, WCAT cannot reconsider its own decisions for reasonableness (*Fraser Health*, supra).

It is important not to apply for reconsideration until you are ready to proceed as a party may apply for reconsideration of the original WCAT decision on each ground on one occasion only.

In view of the finality of these provisions, especially where a decision has not been appealed, any worker who is not completely satisfied with a decision should request a review by the Review Division and if allowed, an appeal to the WCAT. This will preserve a residual right to present new evidence in the future, even if the appeal is unsuccessful.

WCAT decisions are accessible on the website under "research". If you want to view previous WCAT decisions made on applications for reconsideration, you can select "reconsideration grounds," under "type of decision".

G. *Judicial Review (JR)*

A party may apply for judicial review of a WCAT decision by the British Columbia Supreme Court **within 60 days** of the date on which a decision is issued. Under certain circumstances the court may extend the time for applying. Due to clear language in the ATA, JR of WCAT decisions are held to the standard of patent unreasonableness on most questions (constitutional issues and questions of so-called true jurisdiction are exceptions). This is the highest level of judicial deference and limits the courts ability to interfere unless the decision was "openly, evidently, clearly wrong" (*Canada (Director of Investigation and Research) v. Southam Inc.*, [1997] 1 S.C.R. 748; *Fraser Health*, supra). **Possible JR cases should be referred to lawyers as it is very difficult to file and conduct a judicial review without a lawyer's assistance.** See **Chapter 5: Public Complaints Procedures** for more information about judicial review.

Note that if JR and reconsideration are both possible, it is advisable for the worker to file their paperwork for JR within the 60-day time limit and then apply for reconsideration. This ensures that they will still be able to pursue JR if their reconsideration is denied.

VIII. HEALTH AND SAFETY REGULATIONS

The WCB is also responsible for enacting and enforcing health and safety regulations under Part Three of the Act. The *Industrial Health and Safety Regulations* have been replaced with the WCB's *Occupational Health and Safety Regulation*, BC Reg 296/97 (OHS). These regulations can be found online at www.worksafebc.com/publications/OHSRegulation/home.asp. Workers or employers interested in the regulations can be referred to the Board's Health and Safety Department. The date of enactment should always be checked to determine which version was in effect at the time of injury.

A. *A Worker May Refuse Unsafe Work*

Under the existing OHS, Part 3, a worker may refuse work that is unsafe. The worker must not carry out any work process if they have reasonable cause to believe that it would create an undue hazard to the health and safety of any person.

The right to refuse continues until the employer has taken remedial action to the satisfaction of the worker, or an officer has investigated the matter and advised the worker to return to work.

A worker who has exercised their right to refuse unsafe work must immediately report the refusal and the reasons for it to his or her supervisor or to the employer. The worker must remain available at the workplace during normal working hours until the investigation is complete. The employer may give the worker different duties to perform until the matter is resolved, and it may assign another worker to the job in question if the risk is specific to the worker (such as a person with a bad back being told to lift heavy boxes, or an untrained person being told to operate equipment).

B. *Prohibition Against Discriminatory Action*

Section 151 of the WCA states that an employer or union must not take or threaten any retaliatory action against a worker for exercising any of his or her rights under Part Three of the Act. A non-exhaustive list of such discriminatory actions is provided in s. 150. This list includes: suspension, lay-off or dismissal; demotion; reduction in wages; transfer of duties or of location; coercion or intimidation; and the imposition of any discipline, reprimand, or penalty.

Note that the "bare filing of a claim," that is, filing a claim that is a request for compensation only and does not allege OHS violations does not engage the protection of s. 151 (WCAT-2015-01946).

Complaints should be made in writing to the Board within the time limits set out in s. 152. Section 152(2) places the burden of proving that the alleged discriminatory action did not occur on the employer or union as applicable. The Board has been given a wide range of remedies under s. 153. It is important to note that this section is **not** for human rights complaints, but only for retaliation against a worker for exercising the rights provided by the WCB system.

IX. ASSESSMENTS OF EMPLOYERS

The theory behind the workers' compensation system is that the risk of loss through occupational disease or injury resulting from the workplace should be borne by industry as a cost of doing business. The WCA is administered by the WCB, which is an independent administrative agency created by the provincial government. The program is funded by compulsory assessments on employers, which make up the Accident Fund. These assessments must be paid by the employer and cannot be deducted from the employee's pay (s. 14). The Board gets preferential treatment in its power to collect from an employer. An employee whose employer is subject to the WCA is covered by the WCA regardless of whether or not the employer pays premiums.

Industries are divided into classes and sub-classes. The total assessments for each class are fixed according to the principles of collective liability; the Board is to collect sufficient money to cover the past and estimated future costs of all the claims from workers in each sub-class. Each employer then pays its share, based on the size of its payroll and adjusted for the number of claims against the employer under the Board's "experience rating" scheme. One negative effect of the experience rating system is that employers obviously have an economic interest in contesting their worker's claims. This makes the system more adversarial, which might be seen to contradict the principles of Workers' Compensation.

Some self-employed contractors are considered employers under the Act and therefore are assessed as such. These self-employed workers can purchase "personal optional protection" (POP) to cover their own risk of injury, in addition to the assessments they are required to pay to cover their risk as employers. This arrangement is common in the logging, transportation, and construction industries.

X. THE WCB FAIR PRACTICES OFFICER

The WCB has a Fair Practices Officer (Formerly "Chief Complaints Officer" and before that "Ombudsman"), who has been assigned to deal with issues of alleged unfairness related to the WCA. A claimant who has a complaint about a decision must first pursue all available routes of appeal. The Fair Practices Officer may investigate a complaint after all routes of appeal are exhausted. Individuals or groups with complaints about the fairness of WCB decisions, recommendations, actions, procedures, practices, or regulations may contact the WCB Complaints Officer by phone, fax, mail, or in person.

The WCB Fair Practices Officer should not be confused with the province's Ombudsman, who still has authority to investigate complaints against the WCB. The BC Ombudsman's policy is to suggest that all complaints go first to the WCB Chief Complaints Officer, but a worker may ask that the provincial Ombudsman intervene immediately if the Fair Practices Officer is unable to resolve the problem. Advocates are beginning to make more complaints to the BC Ombudsman recently, and students can insist that this be done if the complaint process seems ineffective. See **Chapter 5: Public Complaints Procedures**.

XI. LSLAP'S ROLE AT THE INITIAL DECISION LEVEL

LSLAP students may only assist workers with a few formal procedures at the initial decision level. However, the student's role at this point is still important. If the initial claim is done well, appeals may be avoided. These types of inquiries are usually done by correspondence, but may be in person at the worker's request.

One important aspect of the CMS data management system is the "portals" which allow workers, employers and representatives to access claim files directly. The worker needs to call the Board and obtain an ID and PIN in order to do this. Such access allows an advocate or advisor to see exactly how the claim has been handled.

Students should get a copy of the file and review the relevant documents with the worker. They may also request that the Board provide an opportunity to make submissions prior to the final decision. Some officers will comply with these requests.

It is important to help a client prepare the best possible case at this level. For example, a projected loss of earnings assessment always includes an extensive interview between the Vocational Rehabilitation Consultant and the worker regarding the types of employment that are suitable and available to the worker. The worker should be prepared for this interview, and should be ready to explain issues such as what they are capable of doing, what job activities they cannot perform, and why this is the case. The Board rarely decides that a worker is 100 percent disabled, and workers should therefore be discouraged from expecting such a ruling, unless there is very strong medical evidence of unemployability.

In addition to filing an appeal, a student can contact the officer who made the decision to request that it be reconsidered on the basis of significant new evidence, or to seek further explanation of the officer's reasons. Note that this must take place within 75 days of the original decision.

Initial decision-making at the Board level is extremely important, and very informal in its procedure. In general, if a representative doesn't understand how or by whom a decision will be made, or what factors will be considered, it is always possible to call the Board and ask. The Claims Manual, Workers' Advisors Office, and other sources of information mentioned in **Section I**: **Introduction** of this chapter can also help prepare a successful claim. See **Appendix A** for a checklist for a student conducting a client interview.

A. *Limited Scope Retainers*

It is vital that LSLAP students assisting workers provide clear and limited scope of work letters. Given the tight deadlines it is essential that clients understand when students are no longer providing them with assistance so they do not miss an appeal or review date. Students should carefully consider their own availability as well as that of the supervising lawyer before promising legal assistance.

Additionally, any student providing representation must be sure to inform the Board and/or WCAT if they are no longer representing a client. Section 6.3.1 of the MRPP establishes a presumption in WCAT that a worker's representative will remain as representative until they either declare otherwise or at the end of 2 years, whichever is longer. This means the representative will receive correspondence related to the claim, even if it is the result of a deterioration of an OccD long after the initial claim is settled. This presumption means it is essential to be clear with the client **and** WCB/WCAT as to when LSLAP has withdrawn as counsel.

XII. APPENDIX INDEX

A. LIST OF ABBREVIATIONS

B. REFERRALS

C. RESOURCES

D. CHECKLIST FOR WORKERS' COMPENSATION INTERVIEWS

E. CHECKLIST FOR REVIEW DIVISION APPEALS

F. SAMPLE AUTHORIZATION BY WORKER OR DEPENDANT FORM

A. *List of Abbreviations*

- ASTD: Activity-related Soft Tissue Disorder
- ATA: *Administrative Tribunals Act*, SBC 2004, c 45
- BMA: Board Medical Advisor
- CM: Case Manager
- CMS: Claims Management Solutions
- DA: Disability Awards
- EI: Employment Insurance
- FPO: Fair Practices Officer
- LOE: Loss of Earnings pension
- LTWR: Long Term Wage Rate
- MMR: Maximum Medical Recovery
- MRPP: Manual of Rules, Policy and Procedure
- OccD: Occupational Disease
- OHS: *Occupational Health and Safety Regulation*, BC Reg 296/97
- PD: Practice Directives
- PDES: Permanent Disability Evaluation Schedule
- PFI: Permanent Functional Impairment
- POP: Personal Optional Protection
- R&L: (Medical) Restrictions and Limitations
- RSCM: Rehabilitation Services and Claims Manual (Volumes I and II)
- RTW: Return to Work
- STWR: Short Term Wage Rate
- TPD: Temporary Partial Disability
- TTD: Temporary Total Disability
- TWL: Temporary Wage Loss benefits
- VR: Vocational Rehabilitation
- VRC: Vocational Rehabilitation Consultant
- WCA: *Workers' Compensation Act*, RSBC 1996, c 492
- WCAT: Workers' Compensation Appeal Tribunal
- WCB: Workers' Compensation Board/the Board/Worksafe BC

B. *Referrals*

Unions
Unions provide more representation for injured workers than all other sources combined. If a worker was engaged in employment under a collective agreement when injured, his or her union or former union should be the first resource. Some unions will even help former members with claims arising out of injuries suffered in non-union employment.

Workers' Advisors Offices (WAO)
Website: www.labour.gov.bc.ca/wab
Lower Mainland Regional Offices:

500-8100 Granville Avenue
Richmond, BC V6Y 3T6

Telephone: (604) 713-0360
Toll-free within BC: 1-800-663-4261
Fax: (604) 713-0311

204 - 32555 Simon Avenue
Abbotsford, BC V2T 4Y2

Telephone: (604) 870-5488
Toll-free: 1-888-295-7781
Fax: (604) 870-5494

- This is the primary resource for non-union workers having difficulties with the Board. The advisors have direct access to the claim file and provide workers with detailed, confidential advice about the claim. They also offer very readable written information for claimants.

- The WAO only takes referrals by internet. Claimants must fill out the online inquiry form at the following website: https://www.labour.gov.bc.ca/wab/inquiry/. They will be contacted within 2 business days to set up a telephone appointment with an Intake Administrator.

Employers' Advisors Office
Telephone: (604) 713-0303
Toll-free within BC and Alberta: 1-800-925-2233
Fax: (604) 713-0345 Website: www.labour.gov.bc.ca/eao

Community Legal Assistance Society (CLAS)
300 – 1140 West Pender Street Telephone: (604) 685-3425
Vancouver, BC V6E 4G1 Fax: (604) 685-7611
Toll-free: 1-888-685-6222

- CLAS may be able to help if a client has lost their appeal to the Worker's Compensation Appeal Tribunal (WCAT) and wants the WCAT to reconsider their decision, or a court to overturn the decision; and if the advocate who helped the client at WCAT cannot assist anymore.

WCB Main Inspection Office
6951 Westminster Highway Telephone: (604) 273-2266
Richmond, BC V7C 1C6 Toll-free (outside Vancouver): 1-800-661-2112

- Complaints about violations of health & safety regulations should be directed here.

WCB Fair Practices Office
Street Address: 6951 Westminster Highway, Richmond, BC V7C 1C6
Mailing Address: Telephone: (604) 276-3053
P.O. Box 5350 Stn. Terminal Fax: (604) 276-3103
Vancouver, BC V6B 5L5

- This office can be contacted when all internal remedies have been unsuccessful or if the worker has a complaint about matters that are not subject to appeal, such as rude conduct by WCB staff, failure to answer letters, or unfair procedures.

- Most lawyers who do WCB applications or WCAT appeals require payment in advance. For more information, please see the lawyer referral section.

C. *Resources*

1. Print Resources

Heather MacDonald and Marguerite Mousseau. *Workers' Compensation in British Columbia*, (LexisNexis Canada, 2009)

- A comprehensive overview of the workers' compensation system in British Columbia, written by two members of the WCAT, the senior appeal tribunal.

Internet Resources

WorkSafe BC
Website: www.worksafebc.com

- The Board's own site contains a wealth of material, including the complete Claims Manual, Appeal Division decisions (since January 1, 2000), the complete Reporter series of decisions, and most of the reports and documents listed above. It also has decisions of the old Appeal Division and the Review Division, and statistics and resources.

- A policy and legislation page is located at www.worksafebc.com/en/law-policy with links to an online version of the Act, recent amendments, and various policy and practice materials. This is the most practical way to research current policies and practices, including the Board's two-volume compensation policy manual, which has the force of law.

Workers' Advisor's Office
Website: www.labour.gov.bc.ca/wab/

- This site, which is part of the Ministry of Labour, contains excellent plain language summaries of the key aspects of the system written for the average claimant, and other material as well. This service is free for anyone who is not represented by a union.

Workers' Compensation Appeal Tribunal
Website: www.wcat.bc.ca

- This site provides information about WCAT and various aspects of Workers' Compensation appeal matters. The "How to Appeal" section provides information on how to appeal, enables access to various appeal forms and provides internet links to WCAT publications as well as other resources that can assist in the appeal process. It also contains WCAT decisions, as well as forms required for appeal.

Organizations

Workers' Compensation Advocacy Group
300 - 1140 West Pender Street Telephone: (604) 685-3425
Vancouver, BC V6E 4G1 Fax: (604) 685-7611

- An informal organization open to all advocates for injured workers, including union representatives, private and legal aid lawyers, workers' advisers, injured workers' group leaders, and others. The group meets monthly, and as a recognized stakeholder for injured workers, is regularly consulted by WCB and government about WCB matters.

PovNet's wcb-bc Email List
For more information, contact Jim Sayre at jsayre@clasbc.net, or Penny Goldsmith at penny@povnet.org.

- PovNet sponsors an interactive, confidential email list for workers' advocates. The list enables members to post questions and information about WCB cases and matters, and to respond to other members' postings.

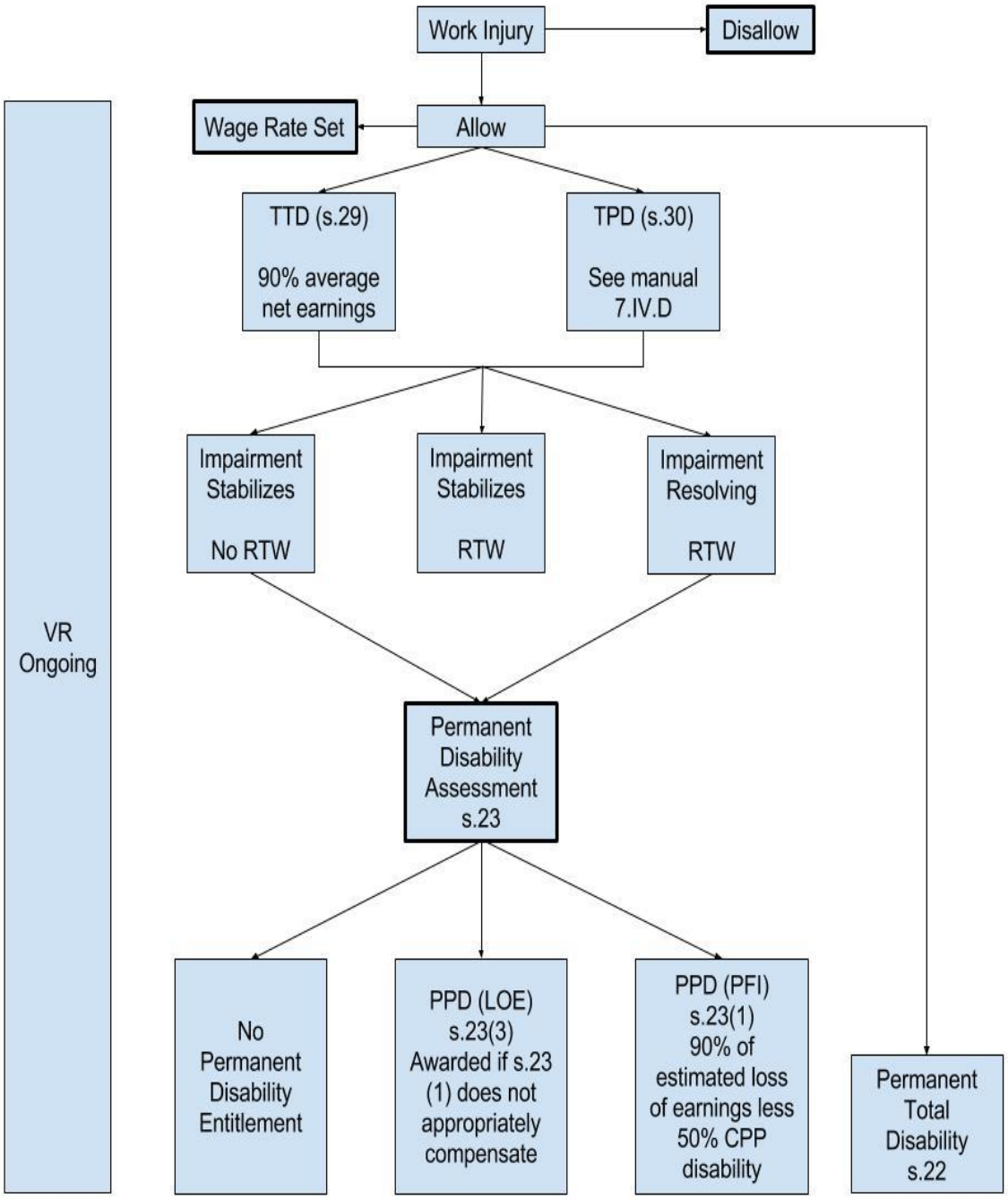
BC Federation of Labour

200-5118 Joyce Street
Vancouver, BC V5R 4H1
Website: www.bcfed.com

Telephone: (604) 430-1420
Fax: (604) 430-5917

- The BC Federation of Labour represents more than half a million workers through affiliated unions in more than 800 locals, working in every aspect of the BC economy.

D. ***Claims Process Flow Chart***



E. *CHECKLIST FOR WORKERS' COMPENSATION INTERVIEWS*

- ❑ Obtain basic client information

- ❑ Note WCB claim number

- ❑ Determine worker's claim status:

    a) Present benefits
    b) On what basis
    c) Pending changes
    d) Relevant decisions
    e) Pending appeals

- ❑ Review worker's claim in full detail:

    a) Date of injury
    b) Nature of injury
    c) Circumstances of injury
    d) Client's job

        i) Remuneration
        ii) Duties - job description
        iii) Length of Employment

- ❑ If claim was accepted, determine:

    a) Initial benefit rate
    b) Did benefit rate change after 10 weeks?

        i) Evidence of long-term earnings given to WCB
        ii) Client's actual work and earnings history

- ❑ Any medical treatment and diagnosis

    a) Client's position
    b) Doctor's advice
    c) Board's position

- ❑ Permanent disability

    a) Return to previous job
    b) Return to another job with same employer
    c) Retraining

- ❑ Long-term loss of earnings?

    a) Other advisor or representatives
    b) Workers' advisor? Trade Union? Other?

F. *CHECKLIST FOR REVIEW DIVISION APPEALS*

- ❑ Interview client
- ❑ Review his or her documents
- ❑ Immediately take note of time limits applicable – they are always to be adhered to
- ❑ Contact the WCB for necessary clarification, reconsideration based on new evidence, etc.
- ❑ Advise client on alternatives such as an application for reconsideration based on new evidence, keeping in mind that the decision is not more than 75 days old since that would prohibit a Board from reconsidering it.
- ❑ File Request for Review application form if instructed by client. Ensure the time limit is met.
- ❑ Request copy of file from Board (this can be done before an appeal is filed if time permits).
- ❑ Review client's file with him or her
    a) Any correspondence
    b) Medical file
    c) Memoranda
- ❑ Identify key issues leading to the decision - examine all aspects
- ❑ Research important issues
    a) Medical - consult family doctor, specialist, etc.
    b) Policy - read Claims Manual, relevant Reporter decisions, etc.
- ❑ Decide on the basic grounds for appeal and relief sought
- ❑ Apply for permission to make a late appeal of a related decision, if necessary
- ❑ Prepare and gather the evidence
    a) Client's testimony
    b) Other witnesses
    c) Documents:
        i Medical legal reports
        ii Affidavits or letters from unavailable witnesses
        iii Income tax returns, etc.
            - Ask Review Division to subpoena non-cooperative witnesses
- ❑ Prepare submissions - do this in writing, as with a trial book
- ❑ Hearing
- ❑ Receive and review Review Division findings with client
- ❑ Consider further appeal to Workers Compensation Appeal Tribunal

G. *SAMPLE AUTHORIZATION BY WORKER OR DEPENDANT FORM*

AUTHORIZATION BY WORKER OR DEPENDANT

I, _____, residing at _____
(Print Name) (Full Address)

_____, _____,
(City & Postal Code) (Telephone Number)

authorize the following:

_____
(Print Name/Title of Representative)

_____
(Representative's Full Address/Organization Name)

_____

_____
(Postal Code) (Telephone Number) (FAX Number, if available)

to be my representative respecting Workers' Compensation Board ("WCB") matters, including any review before the Review Division.

I authorize my representative to obtain or view, from any source whatsoever, including records of physicians, qualified practitioners or hospitals, a copy of records pertaining to my examination, treatment history, and employment. For the purpose of reviews, I consent to the WCB disclosing to my representative the contents of my WCB claim file(s) or any other WCB file(s) or related information to which I am eligible to receive disclosure. I further authorize my representative to act on my behalf in providing evidence and submissions in reviews of such WCB files.

I also acknowledge the WCB may obtain or view, from any source whatsoever, a copy of records respecting the matter(s) under review.

This authorization shall remain in effect for two (2) years, or until I revoke it in writing or until my death, whichever is earlier.

_____ _____
Signature of Worker or Dependant Date

April, 22, 2003