CHAPTER SEVEN: WORKERS' COMPENSATION

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CHAPTER SEVEN: WORKERS' COMPENSATION

This Manual is intended for informational purposes only and does not constitute legal advice or an opinion on any issue. Nothing herein creates a solicitor-client relationship. All information in this Manual is of a general and summary nature that is subject to exceptions, different interpretations of the law by courts, and changes to the law from time to time. LSLAP and all persons involved in writing and editing this Manual provide no representations or warranties whatsoever as to the accuracy of, and disclaim all liability and responsibility for, the contents of this Manual. **Persons reading this Manual should always seek independent legal advice particular to their circumstances.**

I. INTRODUCTION

This chapter covers basic legislation, policy and procedures associated with administrative proceedings under the *Workers' Compensation Act*, RSBC 2019, c 1 [WCA]. The WCA replaced the former *Workers' Compensation Act*, RSBC 1996, c 492 (the "**Former Act**") on April 6, 2020. While there was no substantive change encompassed in this act revision, the section numbers of the WCA have changed significantly.

The WCA is a provincial statute creating a regulatory body called the Workers' Compensation Board (Act, s. 318 [Former Act, s. 81]). Since 2003, Workers' Compensation Board does business under the name of "WorkSafeBC" and is referred to as "the Board" or WCB in this section. The Board has exclusive jurisdiction over compensation to injured workers for workplace injuries, amongst other duties.

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. 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 for injured workers and, in return, workers give up their right to legal action against their employer for work-related injuries and occupational diseases (WCA, s. 127 [Former Act, s. 10(1)]). This approach offers several benefits: it takes workplace injury claims out of the courts, minimizing the use of scare judicial resources as well as limiting cost and delay for the workers; it gives greater certainty of compensation to workers and streamlines the compensation process; and, like any insurance scheme, it spreads losses amongst employers, eliminates the concern about ruinous claims, and provides coverage regardless of fault.

Aside from compensation, The Board's other duties include:

> **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 2 of the WCA [Former Act, Part 3] and in the *Occupational Health & Safety Regulation*, BC Reg 296/97 (the "**OH&S 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

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

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 provides information to workers and their representatives on the overall structure and basic procedures of the Board and its appeal body, the Workers Compensation Appeals Tribunal (the "**WCAT**"). It is intended to assist in working on cases and appeals arising from Board decisions made under the WCA. The vast majority of these cases involve Board decisions denying injured and disabled workers particular compensation benefits. This is not surprising given that Board policies are often complex 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.

Therefore, the primary focus of this material is on compensation matters which may be at issue in Board cases. Assessment and Occupational Health & Safety issues are addressed briefly at the end of the chapter. The Appendices provide information for referrals, community resources, and helpful links for finding law and policy. In particular, the WCA requires the Board, through its Accident Fund, to support the Employer's Advisors Office and the Worker's Advisors Office, which 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, POLICY AND GUIDELINES

A. Legislation

The WCA is the legislation which creates and governs the Board. As set out above, the WCA replaced the Former Act on April 6, 2020. While there was no substantive change encompassed in this act revision, the section numbers of the WCA have changed significantly. As such, this chapter will refer to the section numbers of the current WCA as well as the section numbers from the Former Act.[2]

There are a number of regulations passed under the WCA, the most important being the OH&S Regulation.

In 2004, the *Administrative Tribunals Act*, SBC 2004, c 45 (the "**ATA**") came into effect. The ATA applies to any administrative tribunals in BC that adopt the ATA (or sections thereof) in their legislation. Under the WCA, certain sections of the ATA apply to WCAT including certain procedural requirements and a 60-day time limit for filing a judicial review from a WCAT decision. The ATA does not apply to Claims or Review Division decisions.

Citations for the WCA, key amendments and other relevant legislation are attached in the Appendix.

B. Binding Policy

The WCA sections 339 and 303 [Former Act, ss. 99 and 250] make Board policy binding on all Board decision-makers and appeal bodies (i.e. Review Division and WCAT).[3] The courts have

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[2] A table of concordance is available at <https://www2.gov.bc.ca/assets/gov/about-bc/workers_compensation_concordance_pre_rs2019_to_rs2019.pdf>. Note that this table refers to sections of the current WCA as they were at the time that the current WCA was passed. Future amendments may render this table inaccurate.

[3] Note that WCAT *can* choose not to apply a Board policy in specific circumstances and following specific procedures. See WCA s. 304 [Former Act, s. 251]

determined that the effect of these provisions is to give Board policy a legal status equivalent to subordinate legislation (see below).

The key documents setting out binding Board policy are:

a) The statements contained under the heading "Policy" in the *Assessment Manual* – these policies relate to Part 5: Accident Fund and Employer Assessment of the WCA [Former Act, Division 4];

b) The statements contained under the heading "Policy" in the *Prevention Manual* – these policies relate to Part 2: Occupational Health and Safety of the WCA [Former Act, Part 3]; and

c) The Rehabilitation Services & Claims Manual Volume I and II (the "**RSCM I**" and the "**RSCM II**") (other than explanatory material and the headings "Background" and "Practice") – these policies relate to Part 3: Workers' Compensation System and Part 4: Compensation to Injured Workers and their Dependants of the WCA [Former Act, Part 1];

All legislation and Board policies are available on the Board website at www.worksafebc.com.

In practice, Board policy confines, or attempts to confine, the nature of relevant evidence and provides 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.

This manual focuses on claims compensation issues. As such, the most important policy documents for the purposes of this manual are the RSCM I and the RSCM II. The current RSCM I and RSCM II are 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. The RSCM I applies to claims initiated before June 30, 2002 and the RSCM II applies 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 relevant chapters and policies.

Board policies change from time to time. 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. It is important to ensure you have found the version of an applicable policy as it read at the time a particular decision was made.

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. See section 304 of the WCA [Former Act, s. 251].

C. Binding Policy: Standard of Proof and Evidence

Section 339 (2) and (3) of the WCA require that the Board "make its decision based on the merits and justice of the case, but in doing this the Board must apply the policies of the board of directors that are applicable in that case" and "if the Board is making a decision respecting the compensation or rehabilitation of a worker and the evidence supporting different findings on an issue is evenly weighted in that case, the Board must resolve that issue in a manner that favours the worker". This means that in WCB cases there is a unique standard of proof. Where a case is 50-50, it should be resolved in favour of the worker (an "as likely as not" standard). This is less than the standard of proof used in civil claims. The civil standard is on a balance of probabilities ("more likely than not" or 50% +1).

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D. Non-Binding Guidance

Both WCB and WCAT provide useful interpretive guides that combine policy, important decisions, and best practices. WCB issues Practice Directives 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".

The *Review Division Practices and Procedures* manual (the "**RDPP**") is an important document to review when dealing with a review of a Board decision. While the RDPP is not binding, it outlines standards and practices for the Review Division that may not be obvious on a reading of the relevant sections of the WCA.

WCAT's guidelines are published in the *Manual of Rules, Policy and Procedures* (the "**MRPP**"), available on the WCAT website at www.wcat.bc.ca.

III. INTRODUCTION TO COMPENSATION CLAIMS FOR INJURED WORKERS

Sections 122-125 and 19-20 of the WCA [Former Act, ss. 96 and 113] of the WCA give the Board exclusive jurisdiction over workers' compensation and OH&S matters. The courts have historically respected these strong privative clauses.

Section 122 grants the Board the exclusive jurisdiction to inquire into, hear, and determine compensation matters under Part 4 of the Act [Former Act, Part 1]. Specifically, the board may 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 19 similarly grants exclusive jurisdiction to the Board to inquire into and determine health and safety matters under Part 2 of the Act [Former Act, Part 3].

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 below.

The nature of the worker's injury will generally determine the relevant law and policy. The main types of injuries are:

- Personal Injury (physical or physical/psychological) – sections 134 and 146 of the WCA [Former Act, s. 5];
- Psychological injury (only mental stress) – section 135 of the WCA [Former Act, s. 5.1];
- Occupational Disease – sections 136(1) and 137 of the WCA [Former Act, ss. 6(1) and 6(3)]
- Hearing Loss – section 145 of the WCA [Former Act, s. 7]

IV. 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. Thus, it is extremely important that students do not miss limitation dates. 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 used by the Board 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 unless the reconsideration addresses an obvious error or omission (WCA, s. 123 [Former Act, s. 96(4) – (6)]).

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 earlier. This means the representative will receive correspondence related to the claim, even if it is the result of a deterioration of an Occupational Disease 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.

V. 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. See WCA s. 149 [Former Act, s. 53].

2. **File a claim with WCB**: Any claim must be filed within **1 year** of the date of injury. If a claim is filed later than one year, it may be accepted if it meets the criteria of "special circumstances" under sections 151 and 152 of the WCA [Former Act, s. 55] (see below). Note that even if a claim is accepted, it the application is filed more than three years late, the Board will only pay compensation from the date of the application forward, not from the date of the injury.

3. **Reconsideration of Board Decision**: The Board may reconsider a decision for any reason within **75 days** of the date of that decision. The Board may reconsider a decision at any time if it contains an obvious error or omission. This is a significant change to the Board's reconsideration powers resulting from amendments that came into force January 1, 2021. Outside of these two exceptions, a Board decision can only be changed by an appeal body. See WCA s. 123 [Former Act, s. 96(4) – (6)].

4. **Appeal to the Review Division**: **The time limit for applying for an Internal Review with the Review Division is 90 days.** Workers seeking appeal must always file a Request for Review with the Review Division within 90 days of the date of the decision being reviewed. Workers are not required to submit arguments or evidence at the Request for Review stage, and are only

required to file the Request for Review form, which includes some basic information and a brief description of what remedy 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 can 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 may grant an extension of time if good reasons are shown and an injustice would result if the extension is not granted, but Extension of Time applications are not usually successful. See WCA s. 270 [Former Act, s. 96.2(3) – (5)]

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. See WCA s. 272(6) [Former Act, s. 96.4(6)].

5. **Reconsideration by the Review Division:** the Chief Review Officer may direct a reconsideration of a Review Division Decision on her own initiative within 23 days of the initial decision. While it is the Chief Review Officer who must decide whether or not to issue this direction, a party can write to the Review Division and request a reconsideration. Once an appeal to WCAT has been filed, no reconsideration can occur. In the case of a decision that cannot be appealed to WCAT, a party may apply to the Chief Review Officer for reconsideration on the basis of new evidence. See WCA s. 273 [Former Act, s. 96.5].

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 a Review Division Decision, they must appeal to WCAT within 30 days of the Review Division Decision being issued. Appeals related to prohibited action complaints may be filed within 90 days. This timeline may be extended where special circumstances prevented timely filing and an injustice would otherwise result. See WCA s. 293 [Former Act, s. 243].

   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 Chair 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. See WCA s. 305(4) [Former Act, s. 252(4)].

VI. MAKING A CLAIM

This manual proceeds chronologically through the process of making a claim for compensation with the Board, the adjudication of benefits under a claim, how claims conclude, and the available review and appeal processes. A chart showing this progressions is included in the Appendices. The key phases in a claim are:

- Making a Claim – the Board determines whether or not they will accept the claim;
- Wage Loss Benefits – the Board determines a workers' wage rate and entitlement to wage loss benefits;
- Healthcare Benefits – the Board determines what medical care is necessary to assist the worker with their recovery;
- Permanent Disability – the Board will either decide that an injury has completely resolved (in which case the claim will end) or will decide that the worker will not improve any further and some symptoms are permanent;

- Pension Award – if a worker has a permanent disability, the Board will assess a permanent disability award;

- Vocational Rehabilitation – if a worker has a permanent disability, the Board will provide assistance as required to help the worker return to work with their new limitations.

A. Overview: Reporting and Making a Claim

1. Reporting the Injury (WCA, ss. 149 – 150 [Former Act, ss. 53 – 54])

Key policies applicable to these sections of the WCA are RSCM II, #93.10 – 93.12; 94.10 – 94.20.

All injuries occurring to a worker in the course of their employment (whether it results in time off work or not) should be reported **as soon as possible** by the worker or, if death results, by the worker's dependants, to the superintendent, first aid attendant, or other official in charge of work where the injury occurred. 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. Details as to the type of injuries that must be reported can be found at RSCM II, #94.12.

The employer must complete a report to the Board **within three days** of receiving the worker's report, or immediately if death results. The failure to do so is an offence under the WCA.

2. Making a Claim (WCA, ss. 151 – 152 [Former Act, ss. 55 (1) – (3.3)]

Key policies applicable to these sections of the WCA are RSCM II, #93.20 – 93.25.

A worker has **one year** to make a claim for compensation under ss. 151 and 152 of the WCA [Former Act, s. 55]. If an application is made more than one year, but less than three years, after the relevant injury, the Board may pay full compensation from the date of the injury if the Board is satisfied that special circumstances precluded timely filing. If an application is made more than three years after the relevant injury, the Board may still accept the claim in special circumstances, but can only pay compensation from the date of the filing of the claim forward.

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 or the Appendix 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.

Note that if the worker is completing a paper application, a typed signature is not acceptable (see RSCM II, # 93.25).

3. Obligations Arising under the WCA once a Claim is Made (WCA, s. 153, 163-164 [Former Act, s. 57.1, 56])

Once a worker makes a claim, they are under an ongoing obligation to provide information to the Board that is necessary for the adjudication of their claim. The Board may reduce or suspend benefits if the worker does not provide requested information. See RSCM II, #93.26.

The attending physician must complete a Physician's First Report within three days of first seeing the worker, and must fill out progress reports after each visit related to the workplace injury. See RSCM II, #95.00 – 95.30.

B. EXCEPTION: Election to Proceed by Lawsuit (WCA ss. 127 – 133 [Former Act, s. 10])

Key policies applicable to these sections of the WCA are RSCM II, Chapter 16, #110.00 – 112.40.

Generally, a worker has no right to sue an employer or another worker in the course of their employment for a workplace injury. Instead, they are entitled to benefits from the Board. This is the "Historic Trade Off" discussed above and set out at s. 127 of the WCA [Former Act, s. 10(1)]. Note that the conduct causing the injury must arise out of and in the course of employment before this bar against litigation will apply. Actions outside of the course of employment (for example assault or criminal negligence) do not attract this bar against litigation.

In circumstances where the s. 127 bar against litigation does *not* apply, a worker may choose to sue the person or company responsible for causing a work injury rather than making a claim for Board benefits. In order for a worker to have the right to choose (or "elect") to pursue a legal claim, there must be a party who is potentially liable for the injury and is not an employer or a worker in the course of their employment under the WCA. As set out above, this can occur when the actions of an employer or worker fall outside the scope of their employment. In addition, this can occur when a non-worker or non-employer is responsible for the injury. For example, if a worker is injured in a motor vehicle accident while driving for work, and the other party involved was driving for pleasure, the worker may be able to elect to sue to other driver rather than claiming Board benefits.

Note that, as of May 1, 2021, there is no right to sue in relation to any motor vehicle accident occurring in BC pursuant to the *Insurance (Vehicle) Act*, RSBC 1966, c. 231. As a result, no workers will have any right of election in respect of injuries related to a motor vehicle accident outside of a few narrow exceptions. These exceptions include accidents involving off road / farming vehicles, manufacturer's liability issues (e.g. faulty mechanics / repair), accidents occurring outside of BC, and accidents where the potentially liable driver has committed an offense under the *Criminal Code* (see *Insurance (Vehicle) Act,* ss. 113 – 116).

Where there is a potentially liable party to whom the s. 127 bar does not apply, the worker has a right of election under WCA s. 128 [Former Act, s. 10(2) – (4)]. The worker will be given the opportunity to make this election after applying for Board benefits. If the Board has accepted a claim and determines that there is a right of election, the worker will be provided with an "Election to Claim Compensation in BC" form. The worker must elect to claim compensation **within three months of the date of the injury** unless the Board otherwise allows.

If the worker elects to pursue a lawsuit, they **will not receive any benefits from the Board.** If they elect to receive Board benefits, they will not have the right to bring a lawsuit in respect of their injury.

An election is an important and complex decision (see s 128; previously 10(3) of the WCA) and workers should be referred to the Workers' Advisors Office website at www.labour.gov.bc.ca/wab or assisted before deciding whether to claim compensation.

Where a worker elects Board benefits, the Board becomes "subrogated" to the worker's claim pursuant to s. 130 of the WCA [Former Act, s. 10(6)]. This means that the Board can step into the shoes of the worker and bring any lawsuit that the worker would be able to bring.

Board subrogation is different from the type of subrogation that occurs under insurance contracts. Insurance companies will only become subrogated to actions related to the specific type of benefits they paid out. For example, if an insurance company pays out $10,000 in relation to water damage, that company can only step into the shoes of their insured for claims specifically related to the cause of the water damage. The Board, on the other hand, is subrogated to any and all claims the worker may have connected to their injury. For example, even if the Board paid out only wage loss benefits, the Board can still step into the shoes of the worker and bring a claim in relation to any loss or damage arising from their injury.

When the Board is subrogated to a claim, it 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 23% 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 their right to compensation.

If a worker chooses to pursue court action and is unsuccessful, or the award is less than they 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. Note that the worker **must have Board approval for any settlement** if they wish to apply for "top up" compensation following the settlement of a legal action.

VII. THE CLAIM ACCEPTANCE PROCESS

After a worker makes an application for compensation, a Board officer (typically an Entitlement 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 arose out of and in the course of the worker's employment.
- 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 and clinical opinions from Board Medical Advisors (BMAs). The claim file may also contain detailed phone memos providing the Case Managers 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, Review Division 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 (7-40). 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].

VIII. "WORKER" STATUS

While most people who work in BC will be covered by the WCA, not everyone is covered. No claim will be successful if it is found that an individual does not have worker status.

A. 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. The Assessment Manual at Policy Items AP1-1-1 through AP1-1-7 sets out the principles governing coverage for employers and workers under the WCA. 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 babysitters, 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.

The Assessment Manual sets out certain exclusions at Policy Item AP1-4-1. Issues surrounding variances, specific industries, and personal optional protection (generally used by self-employed individuals) are discussed at Policy Items AP1-4-2 to AP1-8-1.

It is important to note that if a worker chooses to pursue compensation through WCB, it means that they forego their right to sue for damages in tort. Where the tortfeasor is not a worker or employee, WCB may pursue claims against non-workers.

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.

B. Workers in Federally Regulated Industries

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

C. Federal Government Employees

Federal government employees are governed by the *Government Employees Compensation Act*, RSC 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. They are then 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. See RSCM II, #8.10.

D. 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 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 or an employer located outside of BC where the Board has entered into an interjurisdictional agreement (WCA s. 335 [Former Act, s. 8.1]).

There are also special requirements for trucking & transport businesses. On top of WorkSafeBC coverage, employers must check the registration requirements with the Workers' Compensation Authority in the jurisdiction the worker will be working or travelling through. See RSCM II, #112.00 – 112.40

E. Workers Under the Age of Majority

Section 121 of the WCA [Former Act, s. 12] states that a worker under the age of 19 is *sui juris* for the purpose of Part 3 of the Act [Former Act, Part 1], 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.

F. Self-Employed

If a person is a self-employed proprietor or partner in a partnership who operates an independent business then they are not automatically covered under the WCA. In general, they are entitled to seek coverage by purchasing optional workplace disability insurance, also known as Personal Optional Protection. Personal Optional Protection will pay health care, wage-loss, and rehabilitation benefits if the person is injured at work. See Assessment Manual Policy Item 1-4-3.

When a self-employed person with Personal Optional Protection is injured, their claim is processed as if they were a "worker" under the Act (s. 215 [Former Act s.33.6]) and their wage rate is set according to their level of Personal Optional Protection coverage (See RSCM II #67.20).

A labour contractor who does not have Personal Optional Protection and does not operate an independent business may be covered, as a worker by the prime contractor. This is regardless of whether they are eligible for WorkSafeBC coverage or have declined to purchase WorkSafeBC's optional coverage.

Below are examples of situations where a contractor would likely be a worker:

- The contractor supplies only labour
- The contractor supplies labour and minor materials such as nails, drywall tape, or putty
- The contractor supplies labour and a piece of major equipment but is not registered with WorkSafeBC

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.

G. 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 the 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).

IX. DISABILITY AND CAUSATION

A. Types of Claims

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 injuries and conditions.

- Sections 134 and 146 [Former Act, s. 5]: personal injury (physical or physical/psychological)
- Section 135 [Former Act, s. 5.1]: psychological injury only ("mental stress")
- Section 136(1)[Former Act, s. 6(1)]): occupational disease (Occupational Disease) – no presumption of work causation
- Section 137 [Former Act, s. 6(3)]: Occupational Disease – presumption of work causation
- Section 145[Former Act, s. 7]: hearing loss

Detailed policies regarding each of these conditions are set out in the RSCM II. Chapter 3 sets out policies for personal and psychological injuries and compensable consequences. Chapter 4 sets out policies for all Occupational Disease, 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.

B. Injury or Disease or Both?

Because the statutory and policy requirements for an injury and Occupational Disease 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 of the RSCM II 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 may not accept work causation in the initial decision and deny the claim as not meeting the causal standard under WCA ss. 134 and 146 [Former Act, s. 5]. On review or 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. The key for a finding of work causation under s. 134 is "causative significance". Further, it is noted in court decisions that compensability will be denied only if personal or non-employment related factors are so dominant or exclusive that the compensable injury is not a significant causal factor (WCAT-2009-02226, affirmed by WCAT-2011-92511).

In some cases, the worker's pre-existing condition is actually a developing Occupational Disease, 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 Occupational Disease under section 136 and 137 [Former Act, s. 6]. If the Board denies this aspect as well, you may appeal this denial and join the two appeals together at the Review Division or WCAT so an appeal panel may consider the "whole worker".

C. Compensable Aggravation

For both injuries and Occupational Diseases, 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 RSCM II #16.00; for Occupational Diseases, the policy is set out in RSCM II #25.20. It is necessary to distinguish between injuries or death resulting from employment (which are compensable), and injuries resulting from pre-existing conditions or diseases (which are not compensable). There must have been something in the employment activity or situation that had **causative significance** in producing the injury or death. In adjudicating these types of claims, the Board considers:

- The nature and extent of pre-existing injury;
- The nature and extent of the employment activity; and
- The degree to which the employment activity may have affected the pre-existing injury.

If the pre-existing condition meets the test for compensable aggravation, this requires an "aggravation" 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.

If the worker has a pre-existing but non-disabling condition, and the claim is accepted, 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 146 of the WCA [Former Act, s.5(5)] or "proportionate entitlement" whereby compensation is paid only for the increase in disability, rather than the whole disability.

D. Section 134: Personal Injury

Chapter 3 – Compensation for Personal Injury is the key chapter of the RSCM II that applies to s. 134 of the WCA [Former Act, s. 5]. This chapter covers the definition of a "personal injury" as well as "arising out of and in the course of employment" and goes on to cover specific circumstances that can prevent an injury from being accepted and specific losses and consequences that can be included in a claim.

1. Did the Injury Happen at Work?

Under sections 134 and 146 of the WCA [Former Act, s. 5], personal injury or death must arise out of, and in the course of, employment in order to be compensable. It is important to check policies and WCAT decisions for qualifying factors, as they can change.

"Arising out of employment" relates to causation and means that the work must have **causative significance** to the injury. According to well-established jurisprudence, this means that the work does not have to be the sole or even the dominant cause of the injury; 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. 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 to this injury.

"In the course of employment" relates to the employment relationship at the time of injury. It generally refers to whether the injury or death happened at the time and place and during an activity reasonably related to the duties and expectations of the employment. Time and place are not strictly limited to the normal hours or work or on the employer's premises.

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 s.134(3) [Former Act, s. 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 RCMS II #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 they are 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.

RSCM II, Chapter 3 sets out further and detailed criteria for acceptance of a claim under sections 134 and 146 of the WCA [Former Act, s. 5]. 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 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.

2. 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 also **causative significance**, meaning that the initial injury

does not have to be the sole or dominant cause of the secondary injury. It must only be of causative significance greater than being trivial.

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 v Singh (Kovach v WCB)*, [2000] SCJ No 3 decision 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.

See also RSCM II #C3-22.00 – 22.40.

E. Section 136: Occupational Diseases

1. Overview of Compensable Occupational Diseases

An Occupational Disease 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 Occupational Disease formally by listing it in a policy. 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 Occupational Disease, consult the two policy provisions listing the recognized Occupational Diseases: **Appendix 2 (RSCM II)/Schedule 1 (WCA)**, which sets out Occupational Diseases recognized as qualifying for a presumption of work causation for certain industries, and **RSCM II #C4-25.00**, which sets out additional Occupational Diseases recognized by Regulation. Each type has different tests for work causation, which must be met if the Occupational Disease is to be accepted by the Board as compensable.

2. Occupational Diseases listed in Schedule 1 (Appendix 2 of the RSCM II)

Occupational Diseases listed in WCA Schedule 1 [Former Act, 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 Occupational Disease is presumed to have been caused by that work unless the contrary is proven (WCA, s. 137 [Former Act, s. 6(3)]). A presumption of work causation only arises for diseases mentioned in Schedule 1 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.

Occupational Diseases in Schedule 1 include certain kinds of cancers, respiratory diseases including asbestosis, and repetitive strain injuries. If a worker has a Schedule 1 disease but does not work in the listed industry, the worker's Occupational Disease can still be compensable if work causation can be proven under WCA s.136(1) [Former Act, s. 6(1)]. In addition, section 139 of the WCA [Former Act, s. 6.1] sets out a special work presumption for firefighters who suffer a heart attack on the job.

Policy #25.20 of the RSCM II provides a helpful guide to the special rules for a Schedule 1 presumption.

3. Occupational Diseases listed in policy #25.10 RSCM II

Additional Occupational Diseases are listed in RSCM II, #25.10, including many repetitive strain injuries and specific conditions such as plantar fasciitis and Lyme Disease. These diseases must be adjudicated under s. 136(1) of the WCA [Former Act, s.6(1)], where work causation must be proven in each case.

Section 136(1) states that if:

- a worker suffers from an occupational disease and is thereby disabled from earning full wages at the work at which they were 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, RSCM II #C4-25.20 sets out guidance for establishing work causation for Occupational Diseases in general and sets out the Onus of Proof for non-presumptive Occupational Disease causation. This policy can be helpful guidance when framing a submission on causation for a s. 136(1) [Former Act, s. 6(1)] Occupational Disease 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 C4-27.00 – 27.40 of the RSCM II 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 1 [Former Act, Schedule B] (i.e. may or may not qualify for the work related presumption).

RSCM II #C4-28.00 for Contagious Diseases (e.g. scabies)
RSCM II #C4-29.00 – 29.10 for Respiratory Diseases (e.g. asthma, silicosis, asbestosis)
RSCM II #C4-30.00 for Cancers
RSCM II #C4-31.00 for Hearing Loss
RSCM II #C4-32.00 for Other Matters

F. Special Issues for all Occupational Disease cases:

1. Date of Disablement

For an Occupational Disease, **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 (WCA, s. 151 [Former Act, s. 55]). Special rules apply for Occupational Disease late applications and for Federal Workers (see RSCM II #25.20).

2. 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. These benefits may also be claimed by dependants if the worker has died.

3. Standard of Proof

Schedule 1 diseases and the diseases recognized by regulation (RSCM II #25.10) have an "as likely as not" standard of proof for causation (WCA s. 339 [Former Act, s. 99). This means that where the evidence is equally weighted for different interpretations, the interpretation that favours the worker should be preferred. For example, the Supreme Court of Canada upheld a WCAT decision that an unusually high rate of cancer in a group of lab technicians was an Occupational Disease and therefore compensable (*Fraser Health Authority v Workers Compensation Appeal Tribunal*, 2016 SCC 25). 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.

4. 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 136(1)(b), previously 6(1)(b), of the WCA [Former Act, s. 6(1)(b)]). This will simplify the adjudication of future claims for occupational diseases caused by workplace exposure.

G. Section 135 Injury: Psychological Injuries

A worker can claim for diagnosed psychological conditions which arise as a consequence of physical injuries or Occupational Diseases which are accepted under ss. 134, 135, or 146 of the WCA [Former Act, ss. 5 – 6]. Common psychological consequences include chronic pain and depressive disorders. 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. See RSCM II #22.30.

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 135 of the WCA [Former Act, s. 5.1] and RSCM II #C3-24.00 – 24.10.

Section 135 of the WCA [Former Act, s. 5.1] 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. Additionally, determining whether an event was traumatic involves both subjective and objective elements, but the subjective element is paramount (see *Atkins v British Columbia (Workers' Compensation Appeal Tribunal)*, 2018 BCSC 1178 at para 78.) The objective question is only to determine if the event is "identifiable".

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 135 of the WCA [Former Act, s. 5.1] also requires that a psychological condition be diagnosed as a mental disorder by a registered psychiatrist or psychologist.

Section 135 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 s. 135(1)(c) [Former Act, s. 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.

Section 135(2) of the WCA [Former Act, s. 5.1(1.1)] creates a rebuttable presumption for eligible occupations that a worker's mental disorder is a reaction to one or more traumatic events arising out of and in the course of their employment. The presumption applies where the worker is:

- exposed to one or more traumatic events arising out of and in the course of the worker's employment in an eligible occupation; and
- diagnosed by a psychiatrist or psychologist with a mental disorder that is recognized in the most recent DSM at the time of diagnosis, as a mental or physical condition that may arise from exposure to a traumatic event.

The Act also defines an eligible occupation to mean the occupation of a correctional officer, emergency medical assistant, firefighter, police officer, or sheriff.

As of May 16, 2019, this mental health presumption was extended to emergency dispatchers and publicly-funded health-care assistants.

H. Section 145 Injury: 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 ss. 145 and 198 and Schedule 2 of the WCA [Former Act, s. 7 and Schedule D].

X. TIME LIMITS AND PROCEDURES

A. Time Limits

As set out above, the key time limits that apply to making a claim are the reporting time limits and the time limits for filing a claim.

Injuries must be reported by workers to their employers and by employers to the Board as soon as possible. See paragraph VI.A.1 above for details.

Section 151 [Former Act, s. 55] of the WCA requires that generally, a worker must apply for compensation **within one year** of the date of injury. Subsections 151(4) and (5), as well as section 152 [Former Act, s. 55(3.2)], provide several exceptions for when late applications may be accepted:

1. If exceptional circumstances exist which precluded the worker from making an application within one year and the application is less than three years after the date of injury (WCA, s. 151(4) [Former Act, s. 55(3.1)]), the worker's application may be accepted. If a worker's application has been denied because of a late application, please consult Policy #93.22 of the RSCM II to assess what evidence of "exceptional circumstances" may be relevant in that case;

2. Even after more than three years post-accident, the Board may still accept a claim based on "exceptional circumstances", however the Board can only pay compensation from the date of the application forward, not from the date of the injury (WCA, s. 151(5) [Former Act, s. 55(3.1)]);

3. If death or disablement is due to an occupational disease but sufficient scientific evidence did not exist at the time of the application to prove this and there is new scientific evidence regarding the occupational disease causation, the application may be accepted. However, the worker must make the application no more than three years after sufficient medical or scientific evidence became available to the board (WCA, s 152(1) [Former Act, s. (3.2)]); or

4. The Board may also reconsider an old occupational disease decision that meets the Subsections 152(1) and (2) criteria.

B. Application Procedures

Applications to the Board must be made by submitting a Form 6, which will be provided to the worker by the Board when a report is received. This form can also be found online. This form can also be submitted online. Workers can also call Teleclaim at 1.888.967.5377 from 8am to 6pm Monday to Friday.

Note that, even when submitted online, a typed or printed name is not sufficient to meet the signature requirement. The worker must either have a handwritten digital signature they can apply to the form or must print and sign the form before scanning and submitting. See RSCM II Policy #93.25.

Finally, the Board does have the discretion to accept and adjudicate a claim without an application in certain circumstances. See RSCM II Policy #93.23.

C. The Case Management Process

Claims procedures are governed by Chapter 12 of the RSCM II. This manual will not cover all of the policies in that chapter, so it is important to review the nature of the policies in that chapter in order to be able to spot policy related issues in a case.

Once an application has been made, it moves into the case management process whiere initial decision makers will consider the application and decide whether to accept or reject the claim on the criteria set out above. The key feature of case management is a case manager who oversees the delivery of services for the entire life of the claim. This process may also 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 a Return to Work option. The worker, union or other representative, the worker's doctors, and the employer are all expected to participate.

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. The CMS System 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.

1. Initial Decision-Making Process

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) Entitlement Officers (EO)

- Accepts or rejects claims;
- Seeks and reviews required medical documentation;
- May establish initial long-term wage rates;
- Pays short-term disability benefits;
- Authorizes health care payments;
- Calculates overpayment;
- Requests refund from claimant if overpaid;
- Identifies claims requiring claim management; and
- Monitors return-to-work.

b) 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 (or eight weeks for injuries before June 30, 2002);
- Approves or rejects operations or other major treatments;

- Approves workers' expenses for WCB payments;
- Determines when to terminate wage loss benefits because the worker's disability is considered to have "plateaued"; and
- Generally, makes most decisions involving workers including whether to register the worker for vocational rehabilitation services and pension assessments.

c) Vocational Rehabilitation Consultant

- 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 they are considered capable of achieving after the worker has "maximized" their earning capacity in a suitable and available job. This assessment is the core of the Disability Awards Officer's decision concerning a Loss of Earnings 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.

d) 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.) may be consulted regarding medical issues. Furthermore, board medical advisors may be consulted where a second medical opinion is needed.

D. Procedure After Application

The family doctor plays a crucial role in the acceptance and continuance of the worker's claim as well as their 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 Entitlement

Officers, Case Managers, 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.

As set out above, making a claim to the Board results in obligations arising for the worker and for their healthcare professionals (see RSCM II Policies #93.26 and 95.00 – 95.40). A failure to provide information on the part of the worker can result in the claim being suspended (see RSCM II Policy #96.22).

If there is a delay in obtaining outside evidence, the Board may decide to make a preliminary determination and begin paying benefits while waiting for further information (see RSCM II Policy #96.21).

E. Evidence and Investigation

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: for example, 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 evidence from 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 medical diagnosis and medical causation does not need to be proved to the level of scientific certainty. 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)

As with all evidence in the claims process, there is no onus on the worker to prove their injury. Rather, once a claim has been made, the Board gathers the relevant evidence it needs to make a sound conclusion. However, the worker does need to provide some basic evidence of an injury to start the process. As set out above, the standard of proof is "as likely as not", i.e. if the evidence is weighed 50/50, the tie goes to the worker. (See RSCM II, Policy #97.00)

Workers also benefit from several evidentiary assumptions set out at RSCM II Policy #97.20. The RSCM II sets out a number of detailed policies on investigation of claims, use and weighing of evidence, and the powers that the Board has in investigating claims issues for determination. These powers are wide reaching and can be used at any stage of a claim. However, the need for extensive investigation typically occurs at the outset of a claim or when a worker seeks to have a new injury / symptom added to a claim. These policies, as well as policies governing acceptance and disclosure of information on a claim file, are set out at RSCM II Policies # 97.00 – 99.90 and number more than 50 policies. These policies are useful to review generally, but should always be specifically consulted when any issues around evidence / information arises on a claim file.

Also note that certain costs and expenses incurred by a worker in the course of a Board investigation / inquiry / appeal related to a claim can be reimbursed. These policies are set out at RSCM II Policies #100.00 – 100.83)

XI. CLAIM BENEFITS

Once a claim has been accepted by the Board, the process next moves to a determination of what benefits should be paid to the injured worker.

Many RSCM II chapters apply to the adjudication of claim benefits. The most important chapters can be summarized as follows:

- Chapter 5 – Wage Loss Benefits
- Chapter 6 – Permanent Disability Benefits
- Chapter 8 – Compensation of the Death of a Worker
- Chapter 10 – Health Care; and
- Chapter 11 – Vocational Rehabilitation Services

A. 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. After a worker makes an application for a temporary disability, the Board determines whether the worker is totally temporarily disabled and if so, pays full wage loss benefits under Section 191 (previously 29) of the Act. If the worker is only partially temporarily disabled i.e. can work some hours or some duties, the Board will pay partial wage loss under Section 192 of the Act.

The following examples are to illustrate common compensation benefits and scenarios for disability:

- The worker suffers a broken wrist in their dominant hand and cannot perform their job duties as a result. Their doctor recommends a certain number of weeks to recover after which they are cleared to return to work, full duties. The worker makes an application for compensation. If their claim is accepted, the Board sets a short-term wage rate on their claim (based on their average earnings) and the worker is paid temporary wage loss benefits at this rate for their 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 their claim is closed. The worker is not referred for any other benefits such as Disability Awards or Vocational Rehabilitation.

- The worker suffers a more serious injury to their hand (e.g. a crush injury). If their claim is accepted, they again receive temporary wage loss for their time away from work. However, after 10 weeks, the Board issues a new long-term wage rate 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 they can return to work and perform full duties. In this case (as above), the Board will issue a "resolve" decision ending their temporary wage loss benefits and their file will be closed; or

b. His injury is not fully resolved, and they are left with some permanent functional impairment. 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 temporary wage loss benefits on the plateau date but will also refer the worker to Disability Awards to assess the nature and severity of this permanent impairment. In a separate decision, the Disability Awards will rate their impairment according to a schedule and award the worker Permanent Functional Impairment pension in a "Permanent Functional Impairment decision". The Permanent Functional Impairment pension is awarded regardless of whether the worker returns to work or not as it is compensation for the permanent physical impairment, not direct compensation for lost wages.

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

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

The vocational rehabilitation process is set out below and goes through five phases:

- **Phase one:** Tries to have the worker return to the same job with the same employer
- **Phase two:** If unable to return to the same employer, works with worker and employer to modify job or identify job opportunities within the same company
- **Phase three:** If unable to return to the same company, tries to help identify suitable job options related to workers experience and skills
- **Phase four:** If the worker is unable to return to the suitable work in the same or related industry, tries to help the worker to identify options in other industries
- **Phase five:** If the worker needs additional skills in order to return to suitable work, may cover the cost of training to help develop skills.

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

It is possible that vocational rehabilitation is not successful or that a seriously injured worker is simply too disabled to ever be competitively employable.

B. Short Term and Long Term Average Earnings and 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 wage loss related benefits (e.g. loss of earnings, permanent functional disability, and temporary wage loss) are paid according to these rates. If you or your

client believe your benefits do not 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. After 10 weeks, if the worker is still on benefits, the Board sets a long-term wage rate. Both the short-term wage rate and long-term wage rate are set at 90% of net earnings but the calculation of these earnings are different (in most cases) for the two wage rates.

A worker's short-term and long-term wage rates are based on a determination of "Average Earnings" for the worker. This determination is a complicated and fact specific process. There is an entire chapter of the RSCM II devoted to policies surrounding the determination of a worker's average earnings (RSCM II Chapter 9 – Average Earnings). See below for further details.

The general rule for determining a worker's short term average earnings is to take the worker's earnings as of the date of the injury. For example, if a worker makes $100 per day as at the date of the injury, their average earnings will be set at $100 per day. However, this is not an appropriate measure for workers who do not work regular hours. Workers with variable earnings, with more than one job, and several other specific circumstances will have their short term average earnings determined in respect of a certain period of time (e.g. over three months prior to the accident) rather than in respect of the date of the accident. (See RSCM II, Policies #64.00 – 65.05)

The general rule for determining a worker's long term average earnings is to obtain the worker's earning and tax status for the 12 months preceding the injury and base the average earnings for the worker on that information.

For both short-term and long term average earnings, there are exceptions to the above general rules. The exceptions apply workers with a casual pattern of employment, self-employed workers, workers with no earnings, volunteer workers, volunteer firefighters, workers in catholic institution, emergency services workers, apprentices, workers employed for less than 12 months, and workers in "exceptional circumstances" (see RSCM II, Policies # 67.00 – 67.60)

For example, where the Board decides that a worker has a casual pattern of employment, the short-term average earnings will be based on that worker's earnings over the immediately preceding 12 months of employment. Essentially, this means there is no "short-term" wage rate review, only the "long-term" wage rate. 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 their counterpart in a "permanent" job. Where the "casual worker" designation has been made in the short-term wage rate 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 they have 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.

Another example is a "new" worker, defined as when the worker was permanently employed by the accident employer for less than 12 months before the injury. For this type of worker, section 217 of the WCA [Former Act, s. 33.3] 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 217 is not applicable where the worker's employment is deemed casual or temporary.

Under section 218 of the Act [Former Act, s. 33.4], 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. 208(3) [Former Act, 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 their first week, after returning from a six-month layoff. If this worker were designated as a "casual worker", the Board would simply calculate their 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 their short-term wage rate and long-term wage rate and the only argument for a higher rate would be through the exceptional circumstances covered by section 218 of the Act. However, if the worker is found to be in a "highly seasonal" occupation, their EI benefits would add to the calculations of their "average earnings" and greatly increase their long-term wage rate. In addition, their short-term wage rate (for the first 10 weeks) would be set in the usual manner as being their 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 their 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 (RSCM II Policy #65.02).

In addition to determining the appropriate period of time over which to "average" earnings, the Board will also consider what income should or should not be included in that average. These policies are set out at RSCM II, Policies #68.00 – 68.90 and include topics such as overtime, termination pay, salary increases, benefit plans, trike pay, fishers and others.

Note also that the WCA places a cap on wage rates that is set out at Policy #69.00 of the RSCM II.

Once the appropriate averaging period and included income amounts have been determined and averaged, deductions are applied so that the worker is receiving wage rates based on their net (or take home) pay, rather than their gross pay. To calculate the workers average net earnings, the Board deducts probable EI premiums, probable CPP contributions, and probable income tax. These amounts are estimated, not calculated specifically for the worker (see RSCM II, Policy #71.00).

In order to do this, the Board establishes a schedule of deductions that apply to short-term average net earnings and long-term average net earnings (see RSCM II, Policies #71.10 and 71.20). For short-term average net earnings, the board applies the scheduled amount of CPP and EI deductions according to the worker's average earnings. The Board will then deduct income tax based on the following credits: the basic personal amounts multiplied by 1.5 and the credits for CPP and EI contributions.

This will mean that individuals who have dependents or other significant tax credits will end up with a net average earnings amount that may not accurately approximate their actual net earnings. However, this is only an issue for the short-term rate.

For long term average earnings, the Board applies formulas that reflect federal and provincial tax rate and the level of CPP and EI contributions for the immediately preceding calendar year. CPP and EI contributions are determined in a similar manner as in the short-term calculation, and do not necessarily reflect the actual CPP and EI contributions deducted from the worker. However, in

estimating tax deductions, the Board will apply the basic personal amounts, EI and CPP credits, and spousal / dependent and / or caregiver credits.

NOTE: In addition to Chapter 9 of the RSCM II, there are currently 11 practice directives that apply to the calculation of a worker's average earnings and average net earnings. Rather than summarize this complexity, it is best to recognize that the Board's long-term wage rate decision is based on an "average earnings" decision and that the "average earnings" decision is important to review on its particular facts.

Wage rates are established based on the worker's short-term or long-term average net earnings. The worker receives a wage rate based on 90% of their average net earnings. So, once the short-term or long-term average net earnings have been calculated as above, the wage rate paid to the worker will be 90% of that amount.

Once the long-term wage rate is set, the Board uses this long-term wage rate 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 long-term wage rate, 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.

1. 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. 229(1)(8) of the Act [Former Act, s. 35.1(8), 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 long-term wage rate for the purpose of calculating additional benefits under the re-opening.

The applicable policy on re-setting long-term wage rate for re-openings over 3 years is Policy #70.20 of the RSCM II. 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 long-term wage rate was calculated as 75% of gross and the definition of "average earnings" was different. For this worker, their re-opening 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 of 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. Temporary Wage Loss Benefits

The WCA does not define "disability" although it uses this term throughout the Act. Section 191(1) of the Act [Former Act, s. 29(1)] states that if a worker has a temporary total disability ("**TTD**"), the Board must pay full temporary wage loss benefits (calculated according to the steps above). Section 192 of the Act [Former Act, s. 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.

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. For most claims, the Board finds that there is some type of temporary disability:

Temporary Total Disability - worker not working at all: Temporary wage loss benefits paid under s 191 of the Act [Former Act, s. 29] (see RSCM II, Policy #34.10);

Temporary Partial Disability – worker working part-time work at a suitable occupation or deemed suitable occupation and paid partial temporary wage loss benefits under s 192 of the Act [Former Act, s. 30] (See RSCM II, Policy #35.10); OR

Temporary Disability with Light Duties – worker working full time in suitable light duties as per RSCM II Policy #34.11. In this case, the Board usually does not pay the worker any temporary wage loss benefits but the worker's other benefit entitlement (such as health care) is adjudicated under s 192 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 are meant to be a temporary arrangement during a period of temporary disability. Even though no temporary wage loss benefit 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).

There are a number of RSCM II policies that apply to temporary wage loss benefits as set out in Chapter 5 – wage loss benefits. Some key issues covered by those policies include:

- A worker who, while already permanently disabled, suffers a new work injury or relapse (#34.12);
- The minimum level of compensation payable for TTD and TPD wage loss benefits (#34.20 and #35.250;
- Starting date for benefit payments (#34.30);
- Strikes or lay offs (#34.32); and
- Vacation or termination pay (#34.41 and 34.42).

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 (see RSCM II, Policy #34.54). In either case, the Board ceases to pay further temporary wage loss benefits under ss. 191 or 192 of the Act [Former Act, s. 29 or 30] at this point.

D. Health Care Benefits

Health care benefits are payable under ss. 156-161 of the Act [Former Act, s. 21] 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: see RSCM II, Policy #33.00).

Once an injured worker has reached the "resolve/plateau" point of their injury then they receive a permanent disability assessment. This may be an issue for workers who are able to return to work with permanent injuries, especially in accommodated positions. Such worker may be suffering from the effects of their injury but are not considered "disabled". They are entitled to on-going treatment under ss. 156-161 of the Act. Where a worker is denied but disagree with the result, they may 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. Practice directive #C10-1 addresses pain medication, sedatives and hypnotics and was updated in 2017. Compensation for prescribed opioids and other potentially addictive medications are generally limited to four weeks coverage.

The Board has the right to supervise a worker's treatment (Act, ss. 156-161 [Former Act, 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. Medical Aid decisions can be appealed.

E. Income Continuity Benefits

Although classified as vocational rehabilitation benefits (described below), income continuity benefits are payments to provide interim support for the worker after temporary wage loss benefits are 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 vocational rehabilitation plan, they may be refused income-continuity benefits. See Policy #89.10 of the RCSM II for more information regarding the assessment of income continuity benefits.

F. Vocational Rehabilitation Benefits

The Board usually assesses whether a worker needs assistance to return to work at or near the end of their temporary disability. If the worker has a permanent impairment and is not able to safely return to work without assistance, they are referred to Vocational Rehabilitation.

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 vocational rehabilitation is made. If there is no referral, the advocate may make a direct request to the Case Manager and/or appeal the "resolve" or "plateau" decision on the basis that these decisions do not contain a vocational rehabilitation referral, when one is needed. Policy #85.00 and #86.00 of the RSCM II set out the principles, goals, and eligibility criteria for vocational rehabilitation benefits.

Once a vocational rehabilitation referral is made, the Board may provide a large variety of vocational rehabilitation services to injured workers. These are discretionary benefits under s. 155 of the Act [Former Act, s. 16], governed by the policy set out in Chapter 11 of the RSCM II. Generally, the extent of vocational rehabilitation services depends on the nature of the worker's disability.

The policy requires that the assigned Vocational Rehabilitation Consultant consult with the worker and issue a written vocational rehabilitation plan identifying a suitable occupational goal and the vocational rehabilitation services required.

In identifying a suitable vocational rehabilitation plan, the vocational rehabilitation consultant works through five vocational rehabilitation phases, set out in RSCM II, Policies #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 vocational rehabilitation consultant 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 return to work or work conditioning.

2. Phase Two: If the worker cannot return to the same job, the vocational rehabilitation consultant 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 vocational rehabilitation consultant 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 vocational rehabilitation consultant 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 vocational rehabilitation consultant 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 vocational rehabilitation benefits which are authorized for the worker are detailed in the formal vocational rehabilitation plan, which should be provided to the worker. The worker's vocational rehabilitation plan is first published as a document, discussed with the worker, and then is set out in a formal appealable decision.

Vocational rehabilitation 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 they 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 vocational rehabilitation plan and ask the worker to agree to it. The plan must be reasonable. If the worker thinks a vocational rehabilitation plan is not reasonable, they should appeal the vocational rehabilitation decision setting out the vocational rehabilitation plan and ask for a new plan, being as specific as possible as to why the vocational rehabilitation plan is unreasonable, and if possible, what a reasonable vocational rehabilitation plan may be.

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

Vocational rehabilitation benefits, under a formal vocational rehabilitation plan, may be terminated for reasons set out in Policy #88.00 of the RSCM II. These reasons include if the worker is not cooperating, if they withdraw for personal reasons, if they refuse suitable employment or if they are prevented from participating by non-compensable medical, psycho-social or financial problems. If the worker believes that the Board's reasons for terminating vocational rehabilitation benefits are inaccurate or wrong, the termination decision should be appealed. This is particularly important if the worker is failing in vocational rehabilitation due to some aspect of their medical condition.

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

Only the WCB's Review Division can review rehabilitation decisions; the Review Division decisions on vocational rehabilitation cannot be appealed to the Workers' Compensation Appeal Tribunal (Act, s. 288(2) [Former Act, s. 230(2)]) .

While the Board routinely relies on the vocational rehabilitation consultant's decision regarding the worker's employability, WCAT may not consider these vocational rehabilitation decisions as binding on them when adjudicating a loss of earnings pension issue on appeal. For example, a vocational rehabilitation consultant may find that a worker can adapt to working full-time in a particular occupation. If the worker disagrees about this decision, the worker may raise this issue and provide evidence about disability in their appeal of a denial of a loss of earnings pension, both at the Review Division and WCAT. WCAT does, on occasion, make decisions that essentially overturn a Review Division finding as to the employability of a particular worker. However, on judicial review, this may lead to difficulties as it can be argued that WCAT's decision was made without jurisdiction.

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 vocational rehabilitation 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.

G. 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, temporary wage loss 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 or compensation for loss of earnings (detailed below). If a permanent partial disability is accepted, WorkSafeBC will consider both methods and select the method which will provide the larger award.

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 (See RSCM II, Policy #36.10).

1. Permanent or Partial Total Disability Benefits

When the Board determines that a worker has a permanent functional impairment, the Board must determine whether the functional impairment is a Permanent Total Disability ("**PTD**") or a Permanent Partial Disability ("**PPD**"). Sometimes, this will be obvious such as in cases of paraplegia or blindness. In other cases, the Board must conduct an assessment to determine the degree of impairment. If it is 100%, the worker has a PTD. If it is anything less than 100%, the worker has a PPD. This is an important distinction, as PTD and PPD benefits are calculated under different sections of the Act and have different minimum payable amounts.

There are two methods used to calculate a worker's degree of impairment: the functional impairment method – often referred to as the loss of function method ("**LOF**") – or the loss of earnings method ("**LOE**").

The Board will consider both methods, and will use the method that provides the highest award to the worker (Act, s. 195 – 196 [Former Act, s. 23]).

2. Loss of Function Method

The LOF method 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). It is important to note that this is an objective measure, i.e. the amputation of a thumb would result in the same degree of impairment for a carpenter as for an accountant under the LOF method, even though it may be a far more disabling injury for the carpenter.

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 #39.00 of the RSCM II 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 (RSCM II, Policy #39.10).

As stated above, if the LOF method leads to a finding that the worker is 100% disabled, they will be paid PTD benefits pursuant to s. 194 of the Act [Former Act, s. 22]. If the LOF method leads to a finding that the worker is less than 100%, they will be paid PPD benefits pursuant to s. 195 - 196 of the Act [Former Act, s. 23].

Note that even if a worker is found 100% unemployable pursuant to the LOE method described below (i.e. their loss of earnings is complete), it does not necessarily make then 100% functionally disabled, because the LOE method may incorporate personal information about the worker (such as a criminal history) that make the worker unemployable even though the injury did not cause a 100% functional impairment. As such, a 100% unemployable worker will still be paid benefits pursuant to s. 192 of the Act [Former Act, s. 30(2)].

3. Loss of Earnings Method

The LOE method 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. Unlike the objective LOF method, the subjective LOE method takes into account the specific worker. I.e. the LOE method would likely find that the loss of earnings related to an amputated thumb is greater for the carpenter than it is for the accountant, because the accountant can likely return to their pre-injury job, but the carpenter cannot.

Where workers are unable to replace their pre-injury earnings, the WCB often "deems" them capable of earning significantly more post-injury than they are actually 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, they would receive a pension based on the $1000 the Board "deems" them to be losing.

Workers may disagree with Board decisions. Common situations are that the worker believes the Board has underestimated the extent of physical or psychological limitations they have due to their injury and/or pre-injury background or underestimate the demands of the deemed occupations the Board says they can perform. Workers may also disagree with the assessment of what they are capable of earning over the long-term in the deemed occupations, therein deeming them capable of theoretical earnings that exceed what is reasonably suitable for and available for them. If a worker appeals a loss of earning decision, then they should provide evidence of why the decision should be changed.

H. Benefits after Age 65

Policy item #41.00 of the RSCM II 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. WCA section 201(3) states that a determination as to whether a worker would have worked passed the age of 65

can be made by the Board after the individual reaches the age of 63. Note that this change was introduced in 2021 and, before that time, retirement age was assessed as of the date of the injury, regardless of the age of the worker.

At age 63, the worker is asked to provide independent verifiable evidence that they had plans to work beyond age 65. As the provision requiring this later assessment is very new, it is currently not clear what type of evidence will satisfy the Board that the worker intended to work beyond the age of 65.

I. Benefits in Fatality Cases

When a worker is killed as a result of a workplace injury, dependants of that worker can apply to the Board for benefits. Dependants include family members that are dependent on the worker's earning as well as a spouse, child, or parent that had a reasonable expectation of pecuniary benefit from the continued life of the worker (see RSCM II, Policy #53.00).

A child eligible for compensation includes a child less than 19 years of age, an invalid child of any age, and a child less than 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 (see WCA, ss. 168 as well as s. 225 for death before July 1, 1974; [Former Act, s. 19.1]).

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 (Act, s. 170 [Former Act, s. 17(3)(d)]).

A separated spouse may receive benefits based on the amount of support the deceased worker would likely have contributed had they survived (s 178; previously 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.

Benefits in fatality cases can be complex, particularly if any apportionment between dependants is required. Chapter 8 – Compensation on the Death of a Worker of the RSCM II should be consulted.

J. 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 their dependents.

The Board may also divert compensation from a worker for the benefit of their dependents if the worker is not supporting them.

Under s. 153 of the WCA [Former Act, s. 57.1], the Board may withhold or reduce benefits for any period the worker does not provide the 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.

K. 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.

L. "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 vocational rehabilitation or pension decision. Additionally, it is important to note the decision that is issued at the end of a period of temporary disability. This decision, referred to as a "resolved/plateau" decision, usually includes several key decisions, each of which may be appealed. Briefly, the decisions usually embedded in the "resolve/plateau" decision include:

1. Has the Worker's Injury/Occupational Disease 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 Occupational Disease 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 (wage loss 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 RSCM II Policy #34.54 and the worker is entitled to a referral to Disability Awards and (sometimes) Vocational Rehabilitation.

The issue of "fully resolved" vs. reached a 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 (with no disability so no wage loss) does not mean that the injury is "fully resolved"; the injury may have stabilized into a permanent impairment that 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, RSCM II 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).

2. 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 by considering:

a) Have all the compensable conditions been considered? And

b) Is it appropriate given the criteria in RSCM II 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 temporary wage loss benefits until then.

3. What Permanent Conditions are Accepted and what Conditions are Denied?

In the plateau decision letter, the Case Manager 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 Case Manager 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.

4. 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 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 RSCM II Policy #16.00 for injury and Policy #25.20 for Occupational Disease, if the post-plateau condition is not significantly worse than before the injury, then the condition was not permanently aggravated by the work injury/Occupational Disease. 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 (RSCM II 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.

5. 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.

6. Can the Worker Return to the Pre-Injury Job?

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 return to work 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 temporary wage loss benefits, a new plateau date, additional permanent conditions, etc., the return to work finding of fact can be addressed in the context of these additional issues.

However, if there are no other issues in the plateau decision other than this return to work finding, the plateau decision should be appealed on the grounds that the worker cannot return to their pre-injury job and is entitled to additional vocational rehabilitation benefits. Framing the appeal issue in this way ensures that the Review Division has an entitlement decision to address.

7. If Not, Referral to Vocational Rehabilitation

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

XII. APPEALS

If the worker (or the employer) disagrees with a Board decision, they may appeal the decision to the Review Division ("**RD**") **within 90 days of the Board's 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.

Section 123(1) of the Act [Former Act, s. 96(4)] does allow the Board to "reconsider" **any** past decision, on its own initiative, but s. 123(2) of the Act [Former Act, 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 videotape may show that the worker is less disabled than claimed) or if there is a clear error or omission. The Board interprets this to mean that the reconsideration **must be completed**, not just initiated, by the 75th day.

Please note that once a request for a review has been filed, the CM is no longer allowed to proceed with a reconsideration.

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.
- a decision respecting an application to reopen a matter because of a recurrence of injury or significant change in a compensable medical condition.

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. Once a reconsideration is directed by the Chief Review Officer, the Review Division 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.

Once the period for directing a reconsideration has passed, the matter must be appealed to WCAT. 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. The matter must be taken to judicial review.

1. 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**.

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 (Act, s. 288 [Former Act, s. 239] and *Workers Compensation Act Appeal Regulations*, BC Reg 321/2002):

- a response to a workers complaint respecting prohibited action or failure to pay wages (Act, s. 50 [Former Act, s. 153])
- decisions respecting vocational rehabilitation (Act, s. 155 [Former Act, s. 16]);
- amount of a functional pension if the possible range is 5% or less, and commuting a pension into a lump sum payment (Act, ss. 195, 230 and 231 [Former Act, ss. 23 and 35]);
- decisions applying procedural time limits specified by the Board under s. 338 of the Act [Former Act, s. 96(8)];
- decisions refusing to allow an extension of time to file a request for review (Act, s. 270(2) [Former Act, s. 96.2(4)]);
- decisions relating to the conduct and procedural policies implemented by the Review Division for the internal review (Act, ss. 272(2) to (5) and (8) [Former Act, s. 96.4(2) to (5) and (7)]);
- orders by the chief review officer as to whether or not to suspend the operation of a decision pending completion of the review (Act, s. 270(3) [Former Act, s. 96.2(5)]);
- decisions about whether or not to refer a decision back to the Board following completion of the Review Division hearing (Act, s. 272(9)(b) [Former Act, 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. 288(2)(b)-(e) of the Act [Former Act, s. 239(2)(b) - (e)].

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 (pre-revision WCA s 254 as interpreted in *Preast v Workers' Compensation Appeal Tribunal*, 2015 BCCA 377; this likely applies to its revised equivalent, the current s 308). 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.

1. Appeal Procedure – Workers' Compensation Appeal Tribunal

The best starting point to prepare an appeal to the WCAT is to go to the website: www.wcat.bc.ca. The "Resources" section provides access to various appeal forms, as well as an info sheet with further information on the appeals 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. After WCAT makes a decision to allow an appeal, WCB implements it into its decision.

Note that WCAT can reimburse workers for the cost of acquiring medical reports that are reasonably useful to the hearing.

2. Clarifications, Corrections, Missed Issue

WCAT may **correct** accidental errors or omissions (such as typographical or numerical) if the appellate requests corrections**.** The appellate should request clerical corrections as soon as possible and WCAT aims to have it amended within 90 days. WCAT may **clarify** their decision if it is not clear. The appellate must request clarification in writing within **90 days** of the date the decision was served, and the panel will decide if clarification is necessary. If WCAT did not **decide** on an issue in the appeal, the appellate must request this in writing to the Tribunal Counsel Office. If the panel that made the decision agrees that they did not decide on an issue in the appeal, then they will complete the decision by writing an addendum to the decision.

3. Reconsideration of WCAT Decisions

WCAT may reconsider a final decision for very limited reasons after its reconsideration powers were considered by both the BCCA and the SCC in the *Fraser Health Authority* case, supra.

Under the WCA, a WCAT panel may change the outcome of a WCAT decision if there is new evidence. In addition, WCAT may still reconsider a WCAT decision under common law grounds if there is procedural unfairness or a true **jurisdictional error**.[4] On these grounds, WCAT may rehear all or part of the appeal and come to a different conclusion. However, WCAT **cannot** change the outcome of a WCAT decision because it is incorrect, unreasonable, or patently unreasonable. In this respect, the WCAT decision is final, reviewable only by a court on judicial review, with a time limit to apply for judicial review of 60 days under the Administrative Tribunal Act.

Information regarding reconsideration of WCAT decisions is available on the Post-Decision Information Guide on the WCAT website. There is **no time limit** on applying for reconsideration. To apply for reconsideration, a worker may fill out the Application for Reconsideration form and send it in to Tribunal Counsel Office. A worker can also apply for reconsideration by writing a letter to the Tribunal Counsel Office explanation how they meet the grounds for reconsideration.

WCAT makes a **jurisdictional error** if it:

- decided on something it had no power to decide (Example: if WCAT tried to make a binding decision on a residential tenancy issue when it only has authority to make decisions on workers' compensation issues);
- failed to decide on something it was supposed to decide (Example: a worker properly appealed a decision and WCAT refused or failed to make a decision);
- was procedurally unfair (Example: WCAT was unfair in its decision-making process, such as refusing to allow a worker to make submissions for an appeal).

[4] Note that a "true jurisdictional error" is an argument that should be used with caution, as the SCC has ceased recognizing jurisdictional questions as a separate category of questions separate from any other type of question on judicial review. See *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65,paras 65 - 68

Section 310(3) of the WCA [Former Act, s. 256(3)] allows for a party to a completed appeal to apply for reconsideration of a decision based on new **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 each ground, so it is important that they are ready. This can be done at the same time or separate times for each ground. If applying for reconsideration of evidence, include the new evidence in the application. 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 unreasonableness, patent unreasonableness, or error (Fraser Health, supra).

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 “prepare your case” which is listed under “appeal a decision”. To view previous WCAT decisions made on applications for reconsideration, you can select “Search past appeal decisions ” under “review decisions for appeals that are similar”.

C. Judicial Review (JR)

A party may apply for judicial review at the same time that they apply for a reconsideration of a decision from WCAT. A party must 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 *Administrative Tribunal Act*, Judicial Review 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 court's 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 Judicial Review 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 Judicial Review and reconsideration are both possible, it is advisable for the worker to file their paperwork for Judicial Review within the 60-day time limit and then apply for reconsideration. This ensures that they will still be able to pursue Judicial Review if their reconsideration is denied.

NOTE: According to *Denton v British Columbia (Workers' Compensation Appeal Tribunal),* 2017 BCCA 40, where an appeal raises constitutional issues, those issues must be raised prior to the JR stage at the British Columbia Supreme Court. Both the Review Division and WCAT have the authority to hear constitutional issues.

D. 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 occasionally advisable in cases where all information is needed. At times, the Board may not disclose all of the relevant evidence in its possession. 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.

XIII. HEALTH AND SAFETY REGULATIONS

The WCB is also responsible for enacting and enforcing health and safety regulations under Part 2 of the Act [Former Act, Part 3] through WCB's *Occupational Health and Safety Regulation*, BC Reg 296/97 (OHS). These regulations can be found online athttps://www.worksafebc.com/en/law-policy/occupational-health-safety/searchable-ohs-regulation/ohs-regulation 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 2, 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 their 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 48 of the WCA [Former Act, s. 151] states that an employer or union must not take or threaten any retaliatory action against a worker for exercising any of their rights under Part 2 of the Act [Former Act, Part 3]. A non-exhaustive list of such discriminatory actions is provided in s. 47 of the Act [Former Act, 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. 48 of the Act (WCAT-2015-01946).

Complaints should be made in writing to the Board within the time limits set out in s. 49 of the Act [Former Act, s. 152]. Section 49(4) of the Act [Former Act, s. 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. 50 of the Act [Former Act, 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.

XIV. 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 (Act, s. 118 [Former Act, 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.

XV. THE WCB FAIR PRACTICES OFFICER

The WCB has a Fair Practices Officer (formerly "Chief Complaints Officer") 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 BC 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 Fair Practices 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**.

XVI. APPENDIX INDEX

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
- EO: Entitlement Officer
- 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 l996, c 492
- WCAT: Workers' Compensation Appeal Tribunal
- WCB: Workers' Compensation Board/the Board/Worksafe BC

B. List of Cases

- *Albert v British Columbia (Workers' Compensation Appeal Tribunal)*, 2006 BCSC 838
- *Atkins v British Columbia (Workers' Compensation Appeal Tribunal)*, 2018 BCSC 1178
- *Canada (Director of Investigation and Research) v Southam Inc.*, [1997] 1 S.C.R. 748
- *Chima v Workers' Compensation Appeal Tribunal*, 2009 BCSC 1574, 2007 BCSC 1580
- *Cowburn v Worker's Compensation Board of British Columbia*, 2006 BCSC 722
- *Denton v British Columbia (Workers' Compensation Appeal Tribunal),* 2017 BCCA 40
- *Fraser Health Authority v Workers' Compensation Appeal Tribunal*, 2014 BCCA 499
- *Kovach v Singh (Kovach v WCB)*, [2000] SCJ No 3 [Kovach]
- *McKnight v Workers' Compensation Appeal Tribunal*, 2012 BCSC 1820
- *Macrae v Workers' Compensation Appeal Tribunal*, 2016 BCSC 133
- *Page v British Columbia (Workers' Compensation Appeal Tribunal)*, 2009 BCSC 493
- *Preast v Workers' Compensation Appeal Tribunal*, 2015 BCCA 377
- *Schulmeister v British Columbia (Workers' Compensation Appeal Tribunal)*, 2007 BCSC 1580
- *Snell v Farrell*, [1990] 2 SCR 311

- *Worker's Compensation Appeal Tribunal v Fraser Health Authority*, 2016 SCC 25
- *Young v WCAT*, 2011 BCSC 1209

C. 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, their 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
Fax: (604) 713-0311

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

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 accessible written information for claimants.

- The WAO only takes referrals by internet. Claimants must fill out the online inquiry form at the following website: 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
Vancouver, BC V6E 4G1

Telephone: (604) 685-3425
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
Richmond, BC V7C 1C6

Telephone: (604) 273-2266
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:
P.O. Box 5350 Stn. Terminal
Vancouver, BC V6B 5L5

Telephone: (604) 276-3053
Fax: (604) 276-3103

- 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 in **Chapter 22**.

D. 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.

2. 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.

- To keep updated with changed WCB policies, visit the "Table of Effective Dates & Application of Published Compensation Policy" at www.worksafebc.com/en/law-policy/claims-rehabilitation/compensation-policy-dates

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.

- The Post Decision Guide on the website provides information on what can happen after WCAT makes a decision and how to request reconsideration. This can be located at http://www.wcat.bc.ca/research/WCAT_publications/appeal_guides/pdf/post_decision_guide.pdf.
- All of WCAT's previous decisions are public and can be found at http://www.wcat.bc.ca/search/decision_search.aspx
- To apply for reconsideration, visit http://www.wcat.bc.ca/appeals/after/reconsideration.html

3. 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.

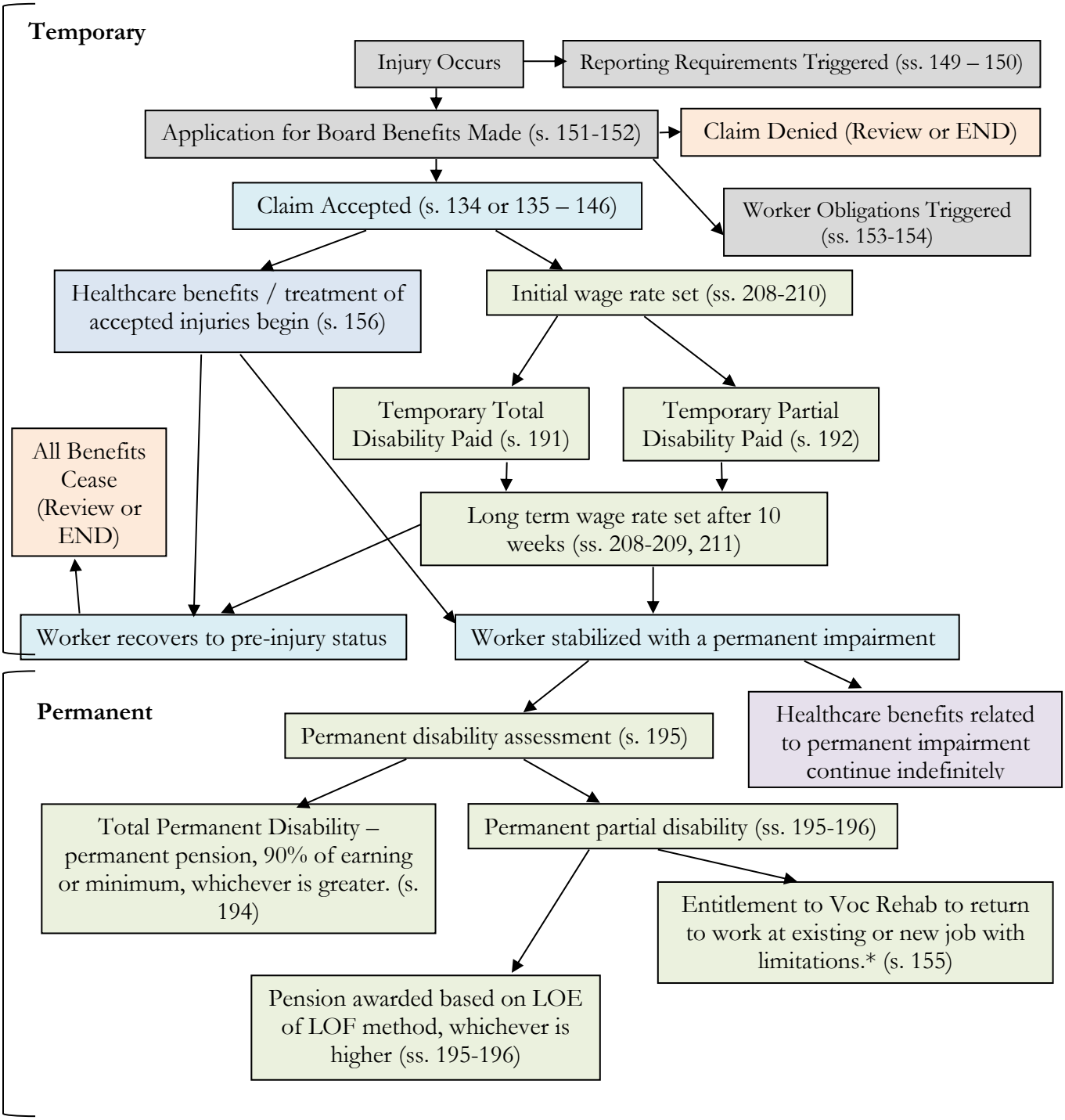
PovNet's wcb-bc Email List
For more information, contact Jim Sayre at jsayre@clasbc.net, or Penny Goldsmith at penny@povnet.org.

- 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 Telephone: (604) 430-1420
Vancouver, BC V5R 4H1 Fax: (604) 430-5917
Website: www.bcfed.com

- 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

E. Claims Process Flow Chart



*While officially VR does not begin until a permanent partial impairment that prevents return to the pre-injury job is accepted, where it is clear that this will occur, VR interventions such as training and job search assistance often begin during the temporary disability phase.

F. 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?

G. CHECKLIST FOR REVIEW DIVISION APPEALS

- ❑ Interview client
- ❑ Review their 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 them
    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

H. SAMPLE AUTHORIZATION BY WORKER OR DEPENDENT FORM

WORK SAFE BC

Mail
PO Box 4700 Stn Terminal
Vancouver BC V6B 1J1
Fax
604.233.9777, toll-free 1.888.922.8837
Phone
604.231.8888, toll-free 1.888.967.5377

WorkSafeBC Authorization of Representative

Please complete this form if you wish to authorize WorkSafeBC, including the Review Division, and the Workers' Compensation Appeal Tribunal (WCAT) to give confidential information about you or your business to your representative. You are not required to have a representative for WorkSafeBC matters; however, if you want someone to act for you and speak with us on your behalf, please complete this form in full, sign it, and return it to us.

1. Information about you

Inform WorkSafeBC or WCAT if your contact details change.

Employer account number (if applicable)	WorkSafeBC claim number (if applicable)

☐ Mr. ☐ Mrs. ☐ Dr. ☐ Ms. ☐ Miss	Last name	First name	Middle initial

Title and business name (if applicable)

Mailing address	City	Province	Postal code

Daytime phone number (include area code)	Other phone number (include area code)	Fax number (include area code)

I am

☐ A worker
☐ A deceased worker's dependant
☐ An employer
☐ Other (explain)

2. Scope of representation

My representative will represent me with respect to the following WorkSafeBC matters, including any reviews or appeals that may arise: (check all that apply)

☐ All assessment matters, including the authority to settle such matters
☐ All compensation claims matters, including section 10(8) transfers
☐ All return-to-work matters
☐ All relief of costs matters
☐ All discriminatory action matters
☐ All certificate matters (e.g., first aid, blasting)
☐ All occupational health and safety matters
☐ Section 257 certificate matters, or
☐ Only the following matters (provide claim number or other details)

This authorization refers to ☐ All my claims ☐ A single claim for claim number as noted above

3. Your representative (you may appoint one person or an organization to represent you)

My representative is:

☐ One person — Name of person ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐ Dr. | Relationship

☐ An organization — Name of organization | Contact person ☐ Mr. ☐ Mrs. ☐ Dr. ☐ Ms. ☐ Miss

Representative's mailing address	City	Province	Postal code

Daytime phone number (include area code)	Other phone number (include area code)	Fax number (include area code)

- I consent to WorkSafeBC or WCAT disclosing to my representative the contents of any WorkSafeBC file(s) or related information for which I am eligible to receive disclosure. I authorize my representative to act on my behalf before WorkSafeBC, including the Review Division, or WCAT with respect to those files.
- This authorization form will replace any previous authorization(s) I have submitted to WCAT or WorkSafeBC for the same scope of representation identified in section 2 of this form.
- If I cancel this authorization, I understand that I must notify WCAT and the WorkSafeBC department(s) handling my outstanding matters.
- **For individuals:** This authorization shall remain in effect for two years from the date of signing, unless I cancel it in writing, or until my death, whichever is earliest.
- **For employers:** This authorization shall remain in effect for two years from the date of signing, or until it is cancelled in writing, or the business is no longer active with WorkSafeBC, whichever is earliest.

Signature (you — **not** your representative — must sign here)	Date (yyyy-mm-dd)
X	

WorkSafeBC collects information on this form for the purposes of administering and enforcing the *Workers Compensation Act*. That Act, along with the *Freedom of Information and Protection of Privacy Act*, constitutes the authority to collect such information. To learn more about the collection of personal information, contact WorkSafeBC's freedom of information coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or call 604.279.8171.

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