**2018/07/12-03**

# WORKERS' COMPENSATION BOARD

## RESOLUTION OF THE BOARD OF DIRECTORS

## RE: Health Care Policies in Chapter 10 of the *Rehabilitation Services & Claims Manual*, Volume I

**WHEREAS:**

Pursuant to section 82 of the *Workers Compensation Act,* RSBC 1996, Chapter 492 and amendments thereto ("*Act*"), the Board of Directors must set and revise as necessary the policies of the Board of Directors, including policies respecting compensation, assessment, rehabilitation, and occupational health and safety;

**AND WHEREAS:**

Section 21 of the *Act* provides the Workers' Compensation Board ("WorkSafeBC") with authority to furnish or provide health care that it considers reasonably necessary to cure and relieve injured workers from the effects of their injury;

**AND WHEREAS:**

Policies in Chapter 10 of the *Rehabilitation Services & Claims Manual* ("*RS&CM*") in Volumes I and II provide direction on the provision of health care;

**AND WHEREAS:**

Volume I generally applies to workers injured before June 30, 2002, and Volume II generally applies to workers injured on or after that date;

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**AND WHEREAS:**

By Resolution #2014/03/19-02, dated March 19, 2014 the health care policies in Chapter 10 of the *RS&CM*, Volume II were substantially amended effective January 1, 2015 (the "New Health Care Policies");

**AND WHEREAS:**

The New Health Care Policies were intended to apply to all workers regardless of date of injury;

**AND WHEREAS:**

Since January 1, 2015, there has been inconsistency in appellate decisions regarding which Volume of the *RS&CM* applies when determining health care benefits for workers injured before June 30, 2002;

**AND WHEREAS:**

Policy amendments are required to replace health care policies in Volume I of the *RS&CM* with health care policies in Volume II of the *RS&CM* to clarify that the New Health Care Policies, and amendments thereto, apply to all workers, regardless of date of injury;

**AND WHEREAS:**

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

**THE BOARD OF DIRECTORS RESOLVES THAT:**

1. Amendments to the *RS&CM*, Volume I as set out in the attached Appendix A are approved in accordance with the following:

    a. Items C10-72.00 through C10-75.10 of the *RS&CM*, Volume I are effective July 18, 2018 and apply on or after July 18, 2018; and

b. Items C10-76.00 through C10-84.00 of the *RS&CM*, Volume I are effective July 18, 2018 and apply to health care expenses incurred and health care provided on or after July 18, 2018.

2. Consequential amendments to the *RS&CM*, Volume I as set out in the attached Appendix B are approved.

3. This resolution is effective July 18, 2018.

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

I, Ralph McGinn, hereby certify for and on behalf of the Board of Directors of WorkSafeBC that the above resolutions were duly passed at a meeting of the Board of Directors held in Richmond, British Columbia, on July 12, 2018.

RALPH MCGINN, P. ENG
Chair, Board of Directors
Workers' Compensation Board

**APPENDIX A**

# CHAPTER 10

# MEDICAL ASSISTANCE

## #72.00 INTRODUCTION

Section 21(1) of the Act provides in part as follows:

> "In addition to the other compensation provided . . ., the board may furnish or provide for the injured worker any medical, surgical, hospital, nursing and other care or treatment, transportation, medicines, crutches and apparatus, including artificial members, that it may consider reasonably necessary at the time of the injury, and thereafter during the disability to cure and relieve from the effects of the injury or alleviate those effects, and the board may adopt rules and regulations with respect to furnishing health care to injured workers entitled to it and for the payment of it."

Under Section 21, the Board is responsible for the cost of health care benefits for compensable injuries and occupational diseases. This includes necessary hospitalization, treatment provided by recognized health care professionals, prescription drugs and necessary medical appliances.

## #73.00 RIGHT OF WORKER TO HEALTH CARE BENEFITS

Health care benefits are provided on accepted claims for compensation from the date of injury. They are provided even though the worker is not disabled from earning full wages at the work at which he or she was employed. (1)

Where a worker who is not disabled from working loses time from work to attend treatment or be examined, the worker may be eligible to receive income-loss payments equivalent to wage-loss benefits. This entitlement is fully explained in #83.13.

## #73.10 Prior to Adjudication

A worker will often receive treatment prior to the adjudication of the claim. If this treatment takes place at the Board's Rehabilitation Centre, the Board will meet the cost, whether or not the claim is later accepted. With regard to treatment received elsewhere, the costs are paid only when the claim is accepted. (2)

The Board may pay for medical examinations or consultations on an investigative basis to assist in the adjudication of a claim. (3) However, if the investigation shows that the claimant's condition is not compensable, the Board

will not pay wage-loss for the period of the investigation simply because it has paid for health care benefits.

## #73.20 Duration of Medical Assistance

Coverage for necessary health care continues for as long as the worker continues to experience the effects of a compensable injury or occupational disease, notwithstanding that he or she may not be disabled from working or may be retired from the workforce.

## #73.30 Suspended Claims

No authorization for treatment may be given and no health care benefits are paid for the time that a claim is under suspension. If the claim is subsequently accepted, health care benefits incurred during the suspension are then paid.

## #73.40 Approved Health Care Plans/Canada Shipping Act

Section 21(4) provides that "Where a worker received, before April 1, 1972, health care under

(a) the *Canada Shipping Act* (Canada); or

(b) a health care plan approved by the board,

the worker is entitled to receive, in accordance with this section, additional health care."

As a result of this provision, health care benefits can be provided whether or not the worker is also entitled to such benefits under the *Canada Shipping Act*.

The Act previously allowed for the provision of health care benefits by employers under plans approved by the Board. The plans have now all been discontinued. Under the cancelling agreements, some of the employers are required to pay health care benefits in respect of injuries which occurred prior to the date of cancellation.

## #73.50 Out-of-Province Treatment

### *#73.51 Injury Outside the Province*

For employees of railways, transportation companies, trucking companies, and other personnel whose business may take them to other provinces, emergency medical treatment is allowed at the rates applicable in the locality where it is given. However, this is only for such period as the worker's condition prevents a return to British Columbia. If it appears that treatment will be prolonged, consideration will be given to arranging the return of the worker to British Columbia.

*#73.52 Worker Injured Near the Provincial Border*

Where the worker is a resident of British Columbia and the nearest health care available is in a province, state or territory adjacent to British Columbia, health care benefits may be paid at the rates applicable in that jurisdiction for treatment of short-term disabilities. Subsequent early transfer to British Columbia will be considered in more serious cases.

If, however, a worker injured near the provincial border bypasses available facilities in British Columbia, and by way of personal choice elects to receive treatment outside the province, the Board will not pay in excess of British Columbia rates for that treatment. For instance, this could apply if a worker resident outside the province, but working and injured within its borders, bypassed available and convenient British Columbia facilities and used out-of-province facilities near home.

*#73.53 Worker Leaves the Province to Obtain Specialized Treatment*

It may be necessary to transfer a patient from British Columbia to another province or country for specialized treatment. In such cases, the rates applying in the area where the specialized treatment is carried out are payable, if the transfer is authorized by the Board.

*#73.54 Worker Voluntarily Leaves the Province*

If a worker during treatment desires to leave British Columbia, either temporarily or permanently, the worker is required to discuss the treatment ramifications with the Board. Where leaving the province may impede the worker's recovery, the worker will be discouraged from doing so, and benefits may be suspended pursuant to #78.12 or #78.13.

The Board will generally not pay in excess of British Columbia rates for health care rendered outside the province to a claimant who has voluntarily left the province.

## #74.00 PHYSICIANS AND QUALIFIED PRACTITIONERS

A claimant is entitled to the services of a physician or qualified practitioner. A "physician" is any person registered under the *Medical Practitioners Act* and a "qualified practitioner" is a person registered under the *Podiatrists Act*, the *Chiropractors Act*, the *Dentists Act*, or the *Naturopaths Act*. (4) Thus, the services of medical practitioners, podiatrists, chiropractors, dentists, and naturopathic physicians are covered by the Act. Under Section 21, the Board reserves the right to determine if any particular form of treatment, or provider of treatment, is one that should be recognized for the care of a claimant.

## #74.10 General Position of Physicians and Qualified Practitioners

Physicians and qualified practitioners are required to submit reports to the Board regarding the nature of the worker's condition, the treatment program, the progress of the claimant and to advise and assist workers in making application for compensation. (5)

Every physician or qualified practitioner who is authorized to treat an injured worker is subject to like duties and responsibilities, and any health care furnished by such person shall be subject to the direction, supervision, and control of the Board. (6)

Physicians, qualified practitioners, or other persons authorized to render health care shall confine their treatment to injuries to the parts of the body they are authorized to treat under the statute under which they are permitted to practice, and the giving of any unauthorized treatment is an offence. (7) The maximum fine for committing this offence is set out in Part 1 of Appendix 6 to this manual.

Where, in a case of emergency, or for other justifiable cause, a physician or qualified practitioner other than the one provided by the Board is called in to treat the injured worker, and if the Board finds there was a justifiable cause and that the charge for the services is reasonable, the cost of the services shall be paid by the Board. (8)

### *#74.11 Medical Negligence or Malpractice*

During the progress of a claimant's file, information may come to the attention of Board employees that would lead them to conclude that there was prima facie evidence of medical malpractice or negligence. This may come from the perusal of a single file or the perusal of a series of files where claimants have been treated by the same physician. The following action should be taken in these cases:

1. Where this is brought to the attention of a Board employee or a Board physician, it shall be reported to the Vice-President, Medical Services Division.

2. The Vice-President, Medical Services Division will review the case, together with a committee composed of the following members:

   (a) The Board's General Counsel, or nominee;

   (b) The Director, Medical Services Department;

   (c) The Director, Rehabilitation Centre.

3. The committee will forward to the President a recommendation for action in cases where it is felt that medical malpractice or negligence may have occurred. The President will determine whether to proceed with an action. The claimant will be advised of the President's decision with reasons.

## #74.20 Chiropractors

*#74.21 Duration of Treatment*

After eight weeks of treatment by a chiropractor, or earlier if there is any ground for suspecting that the claimant is not receiving proper treatment, the file must be referred to a Board Medical Advisor for review. The Board Medical Advisor will decide whether a continuance of treatment by the chiropractor should be authorized. It is necessary when such a request is received that the medical factors be considered and the various options evaluated. The main options which should be considered in order of preference are:

1. Have the claimant examined at the Board.
2. Refer the claimant for an orthopaedic or other appropriate specialist consultation.
3. Agree to an extension.

Giving preference to an examination by a Board Medical Advisor is simply an effective method of determining whether options 2 or 3 are necessary or appropriate, or whether some other approach or decision is indicated.

The third option is generally limited to situations where recovery appears imminent. The Board Medical Advisor should be satisfied that the worker's condition is improving. The duration of additional chiropractic treatment must be clearly designated, including the frequency of the treatments. Any extension should be limited to a maximum of four weeks. Where a request is received for an extension beyond this point, approval cannot be granted unless an examination is carried out by a Board Medical Advisor or there has been a specialist consultation. It is expected that extensions beyond 12 weeks would only occur in rare and unusual circumstances.

The reasons for accepting or denying a request for an extension of chiropractic care must be recorded on the claim file and since it is a decision that is reviewable by the Review Division, it must be communicated in writing by the Adjudicator to the claimant and the chiropractor. When recording their opinions on claim files, Board Medical Advisors should clearly define the reasons in support of their recommendations by outlining in what way an extension may produce an improvement in the worker's condition, or alternatively, why further treatments are likely to be ineffective. Under no circumstances should Board Medical Advisors make statements in the claim file such as, "I don't think this should be denied unless it is too frequent" or "I have no objection to chiropractic treatment if the worker thinks it is going to help."

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Situations are occasionally met where claimants receive chiropractic treatments on a long-term basis (for example, one treatment per month for six to twelve months). Such treatments are probably more in the nature of preventative measures or as a means of forestalling future problems. The purpose of section 21 of the *Act* is to provide health care benefits for the treatment of injuries or occupational disease. As such, long-term chiropractic manipulation of this type will not be considered acceptable.

As a general rule, the Board will not pay for more than one treatment by a chiropractor per day. Any exception to this rule should normally be authorized beforehand by the Board. No exception will be allowed on the grounds that the additional treatment is needed to compensate for the bad effects of the journey to the chiropractor when, by seeking treatment from another chiropractor or different type of practitioner at a different location, the journey could have been avoided.

The Board will also not pay for daily treatment nor for house visits after the initial treatment unless the necessity is clearly indicated.

**EFFECTIVE DATE:** October 1, 2007 – Revised to delete references to memos and memorandums.

**HISTORY:** March 3, 2003 – consequential changes as to references to review

**APPLICATION:** Applies on or after October 1, 2007

*#74.22 Scope of Chiropractic Treatment*

The Board has established the guidelines set out below regarding the acceptability of chiropractic treatment.

1. Where chiropractic treatment is directed at the spinal column in respect of complaints in the extremities for which a claim has been accepted, the Board may refuse responsibility for the treatment if it concludes that the injury at work did not affect the spine, but was to the extremities only.

2. Where chiropractic treatment is directed at the spinal column for problems in an extremity and it is accepted that the work injury caused the condition of the spinal column, the treatment may be acceptable if it is concluded that the problem in the extremity arose from that condition.

3. Treatment by a chiropractor to the spine or any other articulations of the body must be reasonable and acceptable treatment for the medical problem experienced by the claimant.

4. Chiropractic treatment to the spinal column is not acceptable where:

   (a) there is clinical evidence to suggest nerve root pressure with definite and progressive neurological findings; or

   (b) there are fractures, dislocations, underlying bony pathology, or other conditions requiring immediate surgical or medical treatment.

5. Chiropractic treatment to the articulations of the extremities is not acceptable in respect of:

   (a) fractures, dislocations, underlying bony pathology or other conditions requiring immediate surgical or other medical treatment;

   (b) soft tissue injuries, including muscle contusions, hematomas, infectious conditions, tenosynovitis, tendinitis, bursitis, epicondylitis, carpal tunnel syndrome and Dupuytren's contracture, but excluding minor sprains and strains arising from an articular injury.

6. Prior to refusing or terminating authorization for chiropractic treatment, the Board Medical Advisor will be consulted and, in appropriate cases, the Board's Chiropractic Consultant.

7. A chiropractor who has been treating a worker will be notified of any decision by the Board to terminate its authorization for that treatment under the terms of this decision.

*#74.23 Examination by the Board*

The Board may call a worker in for a medical examination at any time. (9) Where there is no appreciable improvement during treatment, the chiropractor may ask the Board to call the worker in for examination.

When a worker who has been treated by a chiropractor has been examined at the Board and referred by a Board Medical Advisor to a medical consultant, the chiropractor must be notified by letter.

*#74.24 Consultation with Another Chiropractor*

On a problem case, a chiropractor may ask for consultation with another chiropractor. This may be allowed, but it must be authorized by a Board Medical Advisor. The responsibility for obtaining permission rests equally on the attending chiropractor and the consultant before the consultation is carried out, otherwise, the consultation fee may not be allowed. (10)

*#74.25 Physiotherapy*

Physiotherapy cannot be prescribed by a chiropractor at the Board's Rehabilitation Centre or elsewhere.

Concurrent treatment is discussed in #74.60.

*#74.26 Belts and Back Supports*

The supplying of belts and back supports cannot be granted on the order of a chiropractor, but may be approved by a Board Medical Advisor. (11)

*#74.27 X-rays*

X-rays may be taken for the purpose of assisting a chiropractor in the treatment of a worker, subject to the following:

1. The Board will not pay for full-length views of the spine.

2. With respect to x-rays of the affected anatomical areas of the spine, the minimum examination should be as follows:

   (a) Cervical spine – A.P. and lateral as well as an open-mouth view of the odontoid. Oblique views to be added as indicated.

   (b) Dorsal spine – A.P. and lateral full-length views with additional coned views of areas not clearly shown on the two primary views.

   (c) Lumbar spine – A.P., lateral, and a coned lateral view of the lumbosacral junction (oblique views to be taken in addition, if indicated).

Payment will not be made for x-rays of non-interpretable quality, for x-rays of areas of the body not injured, and for excess, or duplication of, x-rays.

Complete x-ray reports, signed by the chiropractor, must be submitted within seven days. The x-rays should be available to the Board on request.

## #74.30 Dentists

The Health Care Benefits Department accepts responsibility for dental repair for damage caused by compensable personal injury or occupational disease. Payments are based on the fee schedule approved by the Board. Prior to commencing the work, a practitioner should submit an estimate to the Board outlining the proposed treatment. Appropriate authorization will then be given to the practitioner.

Where there are two equally functional treatment plans, the Board authorizes the plan that is expected to be the least costly in the long term. If a worker declines the treatment plan authorized by the Board and proceeds on another treatment plan, the coverage will not exceed the amount of payment that would have been made for the authorized treatment plan.

Where a claim is submitted for work-caused damage to dentures, the claim is adjudicated under Section 21(8)(b) of the Act rather than Section 5 or 6 of the Act. This imposes different requirements for coverage. Further details are contained in #23.00 to #23.70.

Claims for damage to crowns and fixed bridgework are adjudicated as personal injury under Section 5(1) (see #13.00) rather than Section 21(8)(b) of the Act as crowns and fixed bridgework are regarded as part of the natural anatomy.

## #74.40 Naturopathic Physicians

After eight weeks of treatment by a naturopath, or earlier if there is any ground for suspecting that the claimant is not receiving proper treatment, the worker's claim must be referred to a Board Medical Advisor. The Board Medical Advisor may take any of the courses set out in #74.21.

The Board will not pay for house visits after initial treatment, unless the necessity is clearly indicated.

Fees may be paid for simple laboratory procedures such as hemoglobin, erythrocyte sedimentation rate and urinalysis. The Board may also accept fees from a medical laboratory for tests related to the condition under treatment incurred on the worker's behalf.

The Board may accept the costs of normal services from radiologists who provide this service on behalf of injured workers to naturopaths.

The Board may call a worker in for examination at any time. Where there is no appreciable improvement during treatment, the naturopathic physician may ask the Board to call the worker in for examination. (12)

## #74.50 Selection of Physician or Qualified Practitioner

Section 21(7) of the Act provides that "Without limiting the power of the board… to supervise and provide for the furnishing of health care in every case where it considers the exercise of that power is expedient, the board must permit health care to be administered, so far as the selection of a physician or qualified practitioner is concerned, by the physician or qualified practitioner who may be selected or employed by the injured worker."

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Subject to the Board's overriding supervisory power, this provision entitles the claimant to select his or her own practitioner. It should be noted that:

1. The section makes no distinction between the original selection and the changing of a practitioner.

2. The section makes no distinction between a practitioner qualified under the *Medical Practitioners Act* and one qualified under the *Podiatrists Act*, the *Chiropractors Act*, the *Dentists Act* or the *Naturopaths Act*, provided that the practitioner accepts Board patients and the appropriate fee schedule.

In certain situations, the Board may object to the selection made by the claimant, and may object to a change of practitioner. For example, the Board may be likely to object if it appears that the claimant is shopping around to find the practitioner who is thought likely to write the most favourable report. On the other hand, the Board will not object, either to an original selection or to a change, simply on the ground that it does not think the claimant is making the wisest choice, or because the claimant's judgment in the selection differs from the judgment that the Board would itself have made.

Where a worker wishes to make a change of physician or qualified practitioner, the following guidelines apply:

1. Where a worker moves, a new physician or qualified practitioner may be selected in the new community without prior permission from the Board.

2. Where a worker receives emergency treatment from a physician who is not the family physician, the worker may transfer to the family physician.

3. A worker may wish to transfer because of a loss of rapport with his or her attending physician, or because of a preference for a type of treatment available from a different type of practitioner. Where it comes to the attention of the Adjudicator that a worker has made or plans to make a change of this kind, the matter will be referred to a Board Medical Advisor. The change will be permitted unless the Board Medical Advisor concludes that it is likely to be harmful, or so medically unsound that it ought to be prohibited.

4. Where it appears that the worker is shopping around for a most favourable medical report, the matter should be referred to a Board Medical Advisor to consider whether an examination at the Board would be appropriate.

5. If it appears that a worker is making multiple changes of physician or qualified practitioner, the matter will be referred to a Board Medical Advisor to consider whether a rational treatment program is being followed.

If the Board Medical Advisor, or Rehabilitation Centre Physician concludes that a change of physician or qualified practitioner should be refused, the decision must be communicated to all physicians and qualified practitioners concerned, as well as to the worker. The physician or qualified practitioner to whom the refusal relates will be notified that the Board will honour an account for treatment up until the date of the advice, but will not accept responsibility for treatment beyond that date.

Any decision to refuse or terminate treatment by a "qualified practitioner" is not legally defensible if it rests on the general objection to the treatment of any patient by that kind of practitioner. Any decision not to allow a claimant the "qualified practitioner" of choice must be justified by a judgment made in the particular case that the selection would be medically unsound by reason of circumstances relating to that particular case.

A Board Medical Advisor or Rehabilitation Centre Physician may arrange for the claimant to be referred to a specialist, however, the worker is not forced to accept treatment he or she does not wish to receive nor treatment from a doctor against whom the worker has some objection.

A claimant cannot attend a doctor whose right to render health care has been cancelled or suspended under the provisions referred to in #95.30.

## #74.60 Concurrent Treatment

The general view of the Board is that a worker should be under treatment by only one physician or other qualified practitioner at a time.

There are cases, however, where concurrent treatment may be deemed acceptable. For example, the same disability may require treatment by a general practitioner and a specialist, by two or more specialists, or the worker may benefit from treatment by a qualified practitioner with concurrent monitoring by the attending physician.

Where reports indicate a worker is receiving concurrent treatment, the claim will be referred to a Board Medical Advisor or Rehabilitation Centre Physician for review. Where the Board Medical Advisor or Rehabilitation Centre Physician conclude concurrent treatment is reasonable, approval will be granted.

Concurrent treatment will not be refused by the Board simply because it is inconsistent with a rule or policy of a professional organization.

If approval for concurrent treatment is denied, in those cases where medical reports have been submitted within a reasonable time, corresponding health care benefit accounts will be paid to the date of the written notification.

## #75.00 HEALTH CARE RENDERED BY PERSONS OTHER THAN PHYSICIANS OR QUALIFIED PRACTITIONERS

Persons other than physicians or qualified practitioners may be authorized to render health care, for example, optometrists, dental mechanics, nurses and physiotherapists.

## #75.10 Physiotherapists

Physiotherapists, who are members in good standing of the Canadian Physiotherapy Association or the British Columbia Association of Physiotherapists in Private Practice, may provide injured workers the specific types of treatment they are authorized by statute to render.

### *#75.11 Physiotherapy at the Boards Rehabilitation Centre*

The Board may admit workers to the Rehabilitation Centre prior to the initial adjudication of their claims. (13) In third party claims however, a worker has no right to compensation until the worker elects to claim compensation. (14) In such cases the injured worker will not be admitted to the Rehabilitation Centre for treatment until he or she has so elected.

In cases when a request is received for admission to the Rehabilitation Centre for treatment where wage-loss benefits and/or health care benefits have previously been terminated, the decision regarding reopening must be made before admission is allowed.

In order to control absenteeism at the Rehabilitation Centre, the following policy based on Section 57(2) of the *Workers Compensation Act* has been adopted:

1. Each claimant on the original admission to the Rehabilitation Centre will be provided with a copy of notice summarizing this policy.

2. A notice to like effect will be posted on notice boards throughout the Rehabilitation Centre and Residence.

3. All absences, where known in advance, must have the prior approval of the Adjudicator before wage-loss payment may be made.

4. All absences resulting from sickness must be supported by a doctor's certificate before wage-loss payment may be made.

5. Adjudicators will have the discretion to authorize the payment of wage loss for an absence where no prior approval has been obtained or no doctor's certificate has been produced, but where, however, the special circumstances of the case support the maintenance of wage-loss payments.

6. Adjudicators must approve requests by claimants to be excused treatment during the course of a day. If the interruption of treatment is for medical reasons, the advice of a Rehabilitation Centre Physician or Rehabilitation Centre Nurse should be obtained by the Adjudicator before permission is granted.

7. All claimants returning from an absence due to an illness must be examined by either a Rehabilitation Centre Physician or Rehabilitation Centre Nurse prior to resuming their treatment program.

*#75.12 Physiotherapy Given Privately*

The following policy guidelines now apply for all Workers' Compensation Board claimants with the exception of paraplegics and quadriplegics.

1. Physiotherapy prescribed by the attending physician may be continued up to a maximum of **eight weeks** per case.

2. Such physiotherapy treatment shall not exceed one treatment per day.

3. Such physiotherapy shall be rendered by a chartered or registered physiotherapist.

4. The attending physician and the physiotherapist are required to be in communication regarding treatment progress.

5. In cases where the attending physician considers that physiotherapy should continue beyond eight weeks, prior authorization must be obtained from a Board Medical Advisor. This may be done by writing or telephoning the Board. At the time the authorization is given, the period of additional treatment will be specified (up to a maximum of eight weeks additional).

6. Where it is not feasible for the attending physician to obtain prior authorization, the request shall be submitted by the attending physiotherapist.

7. The physiotherapist may also communicate with the Board concerning patient progress. Such communication may be in the form of a letter or copies of progress reports sent to the physician.

8. Any case requiring physiotherapy treatment in excess of 16 weeks total accumulative amount shall be referred to the appropriate Board Medical Advisor/Consultant for consideration of approval to continue beyond this interval.

## #75.20 Nurses

For seriously ill or injured workers who need additional nursing service, the necessary nursing service is determined and provided by the hospital. The Board is not responsible for payment of special duty nursing fees. If the worker or the worker's family desire to have a special nurse in attendance, the cost of employing such special nursing should be met by the worker. If the condition requires additional nursing service, the physician should indicate to the hospital the service necessary and discuss with the hospital any question about these requirements as this matter is outside the jurisdiction of the Board.

Temporary home nursing care is covered where it is specifically required because of the nature of the compensable medical condition. Where care is required permanently, the costs are covered under a personal care allowance (see #80.00).

When a registered nurse is required as nursing escort during emergency transportation, Registered Nurses Association fees will be paid, as well as the nurse's expenses.

Reports received from Canadian Red Cross Society Outpost Hospital nurses can be accepted in lieu of medical reports if there is no physician in the immediate area.

## #75.30 Dental Mechanics

The fees paid to Dental Mechanics cover such necessary reports as the Board may require.

Reports submitted should state clearly the exact extent of dental damage occasioned by the accident, the method of restoration and the fee therefore itemized according to the schedule.

## #75.40 Health Spas and Public Swimming Pools

The costs of using spas, public swimming pools or other exercise programs that are not provided by a recognized health care professional are not recognized by the Board as a health care benefit cost.

## #76.00 HOSPITALS AND OTHER INSTITUTIONS

Only hospitalization that is directly necessary in the treatment of the worker's compensable injury may be paid by the Board.

## #76.10 In-patient Treatment

In-patient per diem rates paid to hospitals are inclusive of all costs associated with the hospitalization. Costs associated with special nurses (see #75.20), beds or any other equipment are covered by the per diem rate and are not paid for separately.

The Board covers the cost of a public ward bed. However, a Board officer may authorize a private or semi-private bed where it is cost effective in minimizing wage loss resulting from a delayed admission.

A private or semi-private room will also be authorized where the critical condition of the claimant requires it.

## #76.20 Short Stay Patients

Out-patient charges, including charges for emergency services, are covered by the Board where hospital services are necessary for the treatment. Where a physician chooses to see a patient in a hospital in lieu of an office visit, this is considered an arrangement between the doctor and the hospital. In such cases, only the doctor's physician services are paid for by the Board.

## #76.30 Private Hospitals

Private hospitals may be utilized for treatment of pre-operative or post-operative patients who require active nursing care. The Board's approval must be obtained before a patient is admitted to such a hospital. If a patient is admitted without such approval, no payment will be made for hospitalization.

The attending physician must report to the Board at regular intervals regarding the patient's condition and the necessity for continued hospitalization.

The Board's approval must be obtained for any absence from the hospital for any purpose other than medical treatment and examination. No payments will be made for hospitalization during such a period of absence unless Board approval has been obtained. Any cases of intoxication, other substance abuse, or misconduct must be reported immediately to the attending physician and the Board.

## #76.40 Laboratory Procedures

Board responsibility is limited to laboratory procedures required for diagnosis and treatment of conditions due to the compensable injury.

## #76.50 Application of Compensation to Worker's Maintenance in Hospital

This is discussed in #49.10.

## #77.00 DRUGS, APPLIANCES, AND OTHER SUPPLIES

In addition to medical examination and treatment, the Act provides for necessary health care benefits in the form of drugs, appliances, and other supplies.

## #77.10 General Position

Accounts for medicine, bandages, and other supplies are payable only when they are prescribed by the attending physician and where medical reports to the Board verify their necessity.

Medicine, bandages and other items provided during an in-patient hospital stay are covered by the inclusive per diem rate. If, however, a claimant is provided an appliance or material for use after discharge, a separate charge is made by the hospital to the Board. This coverage is in lieu of the claimant being required to make the purchase from a medical supply house, such as a pharmacy, following discharge.

The Board may furnish appliances:

1. of a temporary nature to aid in the worker's recovery. The appliance is supplied as a temporary measure only and may not be replaced without the authorization of the Board;

2. of a permanent type when there is a permanent disability. Such an appliance is kept in repair and replaced as required.

Requests for repair or replacement of an appliance will usually be accepted without question when the repair or replacement is such as is reasonable to expect will result from normal wear and tear. This will normally be determined from the Board's experience as to the normal maintenance requirements and normal lifespan of the item in question. When a requested repair or replacement is not, on the face of it, such as is reasonable to expect from normal wear and

tear, investigation will be made as to the actual cause of the request. In general, this means that, on the one hand, responsibility will be accepted if the loss or damage is due to the wear and tear or an accident arising in the claimant's particular style of life. On the other hand, responsibility will be declined if the loss or damage resulted from deliberate or reckless abuse or has occurred with excessive frequency.

The repair and replacement of appliances broken or damaged at work is discussed in #23.00.

## #77.20 Types of Supplies and Appliances

Set out below are some of the supplies and appliances provided by the Board and the conditions under which they are provided.

The list is not all inclusive. A claimant or the treating practitioner may contact the Health Care Benefits Department to determine if a particular item will be covered.

### *#77.21 Eyeglasses*

Where eyeglasses are required because of an injury, the necessary corrective glasses are provided as required, as are artificial eyes. In all cases, hardened lenses are provided. Dark glasses may be supplied if prescribed by the attending physician or specialist as necessary. Frames are also supplied if damaged or not previously utilized.

Contact lenses may be provided at Board rates if the Board Medical Advisor considers they would improve the vision of, for example, an aphakic eye or scarred cornea.

Where an injury results in serious impairment to a worker's sight, the Board may, to protect remaining vision, provide protective eyeglasses. (15) Therefore, if a worker loses the sight or a substantial part of the sight of an eye in an industrial injury, glasses with hardened lenses are provided to protect the remaining sight.

The policy regarding repair or replacement is the same as outlined in #77.10.

### *#77.22 Hearing Aids*

The provision of a hearing aid by the Board is not subject to any fixed monetary ceiling but is generally based on a negotiated fee schedule.

Where a claimant is adjudged entitled to health care benefits for loss of hearing, the Board will provide such hearing aid as is reasonable and necessary to achieve optimum satisfaction for the claimant.

The decision will be made by the Adjudicator generally after receiving medical advice and, if appropriate, input from an Occupational Hygiene Officer.

Where a claimant prefers a binaural hearing aid, this will be provided by the Board if it is expected to meet her or his needs, and it will be provided whether the preference is based on performance expectations or is purely aesthetic.

Claimants are advised not to make a private purchase of a hearing aid. Any such private purchase made will be at the claimant's own expense.

A telephone amplifier may be provided for hearing-loss claimants in cases where it is deemed appropriate.

*#77.23 Artificial Limbs*

Where an injury results in the loss of a hand, foot, arm, or leg, artificial limbs are supplied and kept in repair and replaced as needed. Wherever possible, prosthetic and orthotic supplies should only be requisitioned from facilities which have registered prosthetists and orthotists on their staff.

In all cases of major amputations, early referral to the Board's Rehabilitation Centre in Richmond is desirable (if there are no complications, as soon as the suture line has healed). A prosthesis will be supplied while at the Rehabilitation Centre, where ample time will be allowed for training in its use and for necessary adjustments while under observation.

Workers receiving artificial limbs are also entitled to the clothing allowance referred to in #79.00.

*#77.24 Crutches, Canes, and Wheelchairs*

Crutches or canes are covered where required as a result of the compensable condition.

Wheelchairs are issued to those claimants who are permanently disabled and unable to walk. A wheelchair may be replaced when no longer serviceable, but necessary repairs may be authorized periodically during the life of the chair.

*#77.25 Boots and Shoes*

Special footwear will be provided when:

1. there is a permanent deformity of the foot as a result of a compensable injury and standard footwear cannot be adequately adapted;

2. special footwear is required during rehabilitation or treatment for a temporary disability. This may include outside shoes required as a temporary measure.

Alterations to a worker's own boots and shoes, such as metatarsal bars, heel and sole raises, and arch supports, will be provided as a temporary measure, or on a permanent basis where necessary. The Board may request to examine footwear.

Where a claimant is receiving physiotherapy from a private clinic and it is necessary to purchase running shoes, the Board will reimburse the cost up to $25.00.

*#77.26 Belts and Braces*

Should the claimant's injury necessitate the wearing of a back belt, spinal or leg braces, splints or elastic stockings, these are supplied. This may be on one occasion only to enable the patient to overcome the effects of the injury, or in the case of permanent disability, it would be kept in repair and replaced as required.

The clothing allowance referred to in #79.00 is payable to workers who have to wear a leg brace.

*#77.27 Home and Vehicle Modifications*

With respect to major home and vehicle modifications required due to serious disabilities, the Vocational Rehabilitation Consultant investigates the need for these modifications. Where the renovations or modifications are for vocational purposes, they are considered as a rehabilitation expense. (See #90.00.) Where they are necessary for normal daily living because of the compensable medical condition, they are considered a health care benefit expense.

Examples of home modifications are ramps, elevators, wheel-in showers, grab-bars, doorway widening and wing taps for sinks.

Examples of vehicle modifications are hand controls and van lifts.

Necessary maintenance of the home or vehicle modification where required for medical purposes is also covered.

*#77.28 Medical Supplies for Paraplegics and Quadriplegics*

The Board supplies paraplegics and quadriplegics with all necessary medical supplies pertaining to their disability. These are obtained by contacting the Board's Health Care Benefits Department.

Where necessary, paraplegics and quadriplegics are provided with a range of medical equipment. Examples include hospital-type beds and mattresses, long leg braces, crutches, raised toilet seats, grab-bars, wheelchairs and commodes. The list includes the various items required to take care of bowel and bladder functions. Supplies also include condoms, tubing, darvol bags, suppositories and disposable gloves for example. Costs of water mattresses, waterbeds or alternating pressure pads are covered where needed to prevent skin breakdown or spasm.

*#77.29 Miscellaneous Items*

Generally, an item of equipment designed as a medical appliance (for example, a wheelchair) is acceptable as a health care benefit expense if it is medically required because of the compensable condition. Periodically, however, the Board receives requests to provide equipment not normally considered a medical appliance. Examples are hair-pieces, computers, televisions and specialized sports equipment. Unless the equipment is for the purpose of providing medical treatment for the compensable condition, or the individual is otherwise unable to carry out the normal functions of daily living and the equipment is designed for those reasons, it is not considered a health care benefit expense. In these circumstances, however, consideration may be given to providing such items as a rehabilitation expense.

## #77.30 THE PRESCRIPTION OF NARCOTICS AND OTHER DRUGS OF ADDICTION

The following policy applies:

1. Board responsibility for narcotic analgesics, hypnotic-sedatives and tranquilizers (see examples in Table 1) will be limited to a post-injury or post-surgery period of eight weeks. An extension of this eight-week period may be considered, however, where there are special or extenuating circumstances; for example, where a worker has received, or will receive, a permanent disability pension and requires regular intermittent and limited narcotic preparation for the relief of pain.

2. If an Adjudicator or Payment Clerk continue to receive accounts for these drugs beyond the eight-week limit, the worker's claim will be referred by the Adjudicator to a Board Medical Advisor. The Board Medical Advisor will contact the attending physician by phone where possible, outline the details of this policy, and discuss any special or extenuating circumstances. The Board Medical Advisor will also discuss the use of acceptable therapeutic alternatives such as: N.S.A.I.D.'s, anti-depressives, T.N.S., biofeedback. If necessary, an

extension beyond eight weeks may be recommended by the Board Medical Advisor following this discussion.

3. The Board Medical Advisor's discussion and resulting recommendation will then be documented on the worker's claim file and referred to the Adjudicator.
4. The Adjudicator's decision will be communicated in writing to the worker with a copy to the attending physician.

**Table 1**

1. **Analgesic Target Drugs**

   (a) Analgesic combinations containing 50 mg or more of Codeine
   (b) Pentazocine and combinations (Talwin®, Talwin Compound 50®)
   (c) Oxycodone and combinations (Percodan®, Percocet®, etc.)
   (d) Propoxyphene and combinations (Darvon N®, 642®, 692®, etc.)
   (e) Merperidine (oral) (Demerol®)
   (f) Barbiturate + A.S.A. + Codeine combinations (Fiorinal®, Anadol®, Phenaphen®)
   (g) Anileridine (Leritine)
   (h) Morphine and M.S. Contin and M.O.S.
   (i) Hydromorphone (Dilaudid)
2. **Sedative-Hypnotic Drugs**
   (a) Barbiturates
   (b) Meprobamate
3. **Tranquilizers**
   (a) Diazepam
   (b) Chlordiazepoxide

**EFFECTIVE DATE:** October 1, 2007 – Revised to delete references to memos and memorandums.

**APPLICATION:** Applies on or after October 1, 2007

## APPENDIX A

## #78.00 DIRECTION, SUPERVISION, AND CONTROL OF HEALTH CARE

Health care furnished or provided shall at all times be subject to the direction, supervision, and control of the Board. (16)

It will be noticed that health care "is subject to" the direction, etc., not "under" the direction, etc. The Board has a choice, therefore, about the circumstances in which it will give direction.

## #78.10 Direction, Supervision, and Control of Treatment

All questions as to the necessity, character, and sufficiency of health care to be furnished shall be determined by the Board. (17)

A main purpose of the control of treatment by the Board is to ensure that treatment is not overlooked, and that treatment choices are not overlooked. Much of the work takes the form not of "direction" or "control" but rather suggestions and advice to the attending physician. Insofar as the Board does exercise control, it relates largely to the approval or disapproval of payment for elective surgery. Sometimes, however, it may relate to other matters, such as a direction that the patient be examined by a specialist, or that a particular institution be attended rather than another.

The Board uses its control over treatment to promote recovery, and to exclude choices by patients or doctors that will delay recovery, or create an unwarranted risk of further injury. But the control of treatment by the Board is not intended to exclude patient choices. If there are reasonable choices of treatment, or reasonable differences of opinion among the medical profession with regard to the preferable treatment, or choices to be made that depend on personal preferences, the matter should be regarded as one of patient choice.

Where a treatment or appliance is deemed reasonably necessary and more than one type is suitable, the choice is left to the treating practitioner and the worker. Where, however, the selection of a treatment or appliance will likely result in a significant increase in the length of disability, the Board will normally authorize the treatment or appliance that is the most likely to enable the worker to return to work at an early date. If there is a substantial difference in costs of equally effective treatments or appliances, the Board will authorize the less costly. In such cases, if the worker chooses the more costly option, the Board will cover costs up to the amount that would have been paid for the less costly, but equally effective, option.

Where coverage for a non-standard treatment program, medical appliance or other health care benefit expense is contemplated, prior approval of the Board is

suggested. Either the health care professional or the worker may request this. Failure to do so may result in expenses being incurred that will not be covered by the Board.

Whether the treatment for a disability is an appropriate treatment for approval by the Board is a matter for decision by a Board Medical Advisor.

*#78.11 Authorization of Elective Surgery*

Authorization must be obtained from the Board before carrying out any elective procedures. Authority may be obtained by telephone, FAX, or letter. The Board does not expect the practitioner working under emergency conditions to obtain prior authorization before performing necessary procedures.

A particular surgical treatment will not be refused simply on the ground of a personal preference for an alternative course of action; but it will be refused if it is felt unduly hazardous, having regard to its potential benefits and the risks involved in not having the surgery, or unlikely to promote recovery, or totally unnecessary, or if it would seem reasonable to try less drastic measures first.

The conclusion of the Board Medical Advisor on an application for approval of elective surgery is not limited to approval or disapproval. It may include taking any other steps that the Board Medical Advisor considers would be sound medical practice. For example, if it should appear that the attending physician or the patient is expecting the operation to result in total recovery when it normally results in only limited improvement, the Board Medical Advisor may conclude that the operation should be approved, but that the matter should be discussed further with the treating doctor to try to ensure that the patient is informed of the likely results.

Where there is doubt about the existence of a disability, it is possible for the diagnosis of a Board Medical Advisor for treatment purposes to differ from the conclusions reached by the Claims Adjudicator for claims purposes. In other words, it is a legal and logical possibility for the Board to conclude that a claimant should be classified as a person having a particular disability for the purposes of compensation payments, but classified as a person not having that disability for the purposes of a particular remedial treatment. Suppose, for example, the claim is one for an internal disorder. Medical opinion is uncertain, but indicates about an equal probability that the claimant has this disorder. Applying the terms of Section 99 to the medical evidence, the correct conclusion, for claims adjudication purposes, may well be that the claimant has a disorder, and is entitled to compensation. But if the attending physician is seeking approval of a high risk operation, then, depending on the other variables, the Board Medical Advisor might decide that the surgery should be refused on the grounds that the probability that the claimant is suffering from that disorder is not sufficiently high to warrant the risks of that particular treatment.

In cases where authorization for treatment is not granted, the worker should be made aware of this decision in writing by the Adjudicator with a copy to the attending physician and specialist. The Claims Adjudicator must have this letter reviewed by the Medical Advisor to ensure the medical content is correct. An explanation of the decision should be given so that the worker can make informed decisions about the treatment or its relationship to the injury. The Board Medical Advisor will, except in rare circumstances, discuss this decision in advance with the treating physician or specialist.

If a worker acted reasonably in undergoing unauthorized treatment, compensation will be paid to him or her for the consequences of that treatment. The claim of the attending physician or specialist for payment of the cost of the treatment is, however, determinable by different criteria. The Board may not meet the cost of treatment after authorization for it has been refused. (18) This would depend largely on the degree to which the doctor was aware of the Board's position.

*#78.12 Worker Engages in Insanitary or Injurious Practices*

Section 57(2) provides in part that "The board may reduce or suspend compensation when the worker

(a) persists in insanitary or injurious practices which tend to imperil or retard his or her recovery; . . ."

The following principles are observed in applying this provision:

1. The worker must be made aware that the practice is deemed insanitary or injurious, that it must be discontinued, and that benefits will be reduced or suspended if she or he persists in the practice after that warning.

2. It will not be necessary in all cases for the Board officer imposing the suspension to do so only after securing medical advice to the effect that the practice is indeed insanitary or injurious. To take an extreme example, should an Adjudicator observe a claimant with a broken leg in a cast attempting to remove the cast because it is uncomfortable, it will be obvious to the Adjudicator, although a layperson, that the practice is not conducive to recovery and should be discontinued. On the other hand, in any situation where there is any room for doubt about the insanitary or injurious nature of the practice, it will be necessary for the Adjudicator to seek some medical advice before warning the claimant against a continuation of the practice.

3. Should the practice come to the attention of a Board Medical Advisor in the course of an examination, the claimant should be advised that the practice will retard recovery or tend to lead to further injury and

should be discontinued, and that the Adjudicator will be so advised of this opinion. It will then be the responsibility of the Adjudicator to formally advise the claimant that persisting in the practice will result in reduction or suspension of benefits.

4. Once benefits have been reduced or suspended, the claimant will be advised that an assurance, acceptable to the Adjudicator, that the insanitary or injurious practice will not be repeated, will be sufficient for resumption of full benefits. Of course, should the claimant persist in the practice after such assurance is given, benefits will once again be reduced or suspended forthwith and any further assurances will be received with considerable skepticism.

Section 57(2)(a) has no application where it is discovered after the fact that a claimant has engaged in an insanitary or injurious activity, but that activity has now ceased. The section is intended as an inducement by workers to take more care in promoting their own recovery and, therefore, is only applicable where the activity in question is continuing. However, compensation may be denied without invoking this section if the insanitary or injurious conduct engaged in by a claimant shows that the claimant was not disabled during the period in question, or if the evidence indicates that the disability was due to this conduct rather than to the original work injury.

*#78.13 Worker Refuses to Submit to Medical Treatment*

A claimant will not be forced to accept treatment the claimant does not wish to receive nor treatment from a doctor against whom he or she has objection.

However, Section 57(2) provides that "The board may reduce or suspend compensation when the worker

(a) . . .

(b) refuses to submit to medical or surgical treatment which the board considers, based on expert medical or surgical advice, is reasonably essential to promote his or her recovery."

The term "medical treatment" in this subsection is not limited to treatment performed by doctors. It includes, for example, therapy by paramedical personnel.

Decisions on whether compensation should be reduced or suspended under this subsection are made by the Adjudicator; but there must be an input of medical advice. Where a Rehabilitation Consultant is working on the case, he or she must also be consulted.

Under Subsection 2(b), there must be a clear medical opinion on file that the relevant treatment "is reasonably essential to promote his recovery". There must

be evidence that the worker has been offered that treatment and knows that it is considered by the Board reasonably essential to promote recovery. There must be evidence that the worker was in a position to make a choice, and refused the treatment. Also, the worker must be given a chance to explain before any decision is made.

Subsection 2(b) is not intended to exclude all patient choices, and even when the terms of the subsection are satisfied, the Adjudicator is not bound to reduce or suspend compensation benefits in every case. There is a discretion. For example, if the proposed treatment involves a significant risk of an adverse side-effect, or a questionable prospect of success, or is hazardous, the Adjudicator might well conclude that the refusal to undertake that treatment was reasonable.

*#78.14 Acupuncture*

The Board does not generally accept responsibility for acupuncture. Any exception must be previously authorized. Even where an exception is allowed it is usually only for a short period of time and then only in conjunction with an overall program for dealing permanently with the claimant's problem such as is found at a pain clinic. The Board would not likely authorize the treatment where it was being carried out on a routine long-term basis. Where approval of acupuncture treatment is granted, the number of treatments allowed and the fees payable will be set. Requests for authorization of acupuncture treatment are initially referred by the Adjudicator to the Unit or Area Office Medical Advisor. Where this Board doctor feels that treatment approval should be considered, the claim is referred to the Vice-President, Medical Services Division for a decision. The request should provide details such as the number of treatments, the cost and the expected benefits. Treatments that do not meet the above general criteria are usually denied at the unit or area office level.

## #78.20 Examinations and Consultations

Section 57(1) provides as follows:

> "The board may require a worker who applies for or is in receipt of compensation . . . to be medically examined at a place reasonably convenient for the worker. If the worker fails to attend for the examination or obstructs the medical examiner, the worker's right to compensation is suspended until the examination has taken place, and no compensation is payable during the period of suspension."

The examination may be by the worker's own attending physician, a Board Medical Advisor/Consultant or an outside consultant. The worker will be notified in advance of the type of doctor or practitioner who will do the examination.

## APPENDIX A

*#78.21 Examination at the Board*

A Board Medical Advisor does not arrange to examine a worker on his or her own initiative. If a request is received from an attending physician the Adjudicator is consulted before an examination is arranged.

In all cases, the attending physician will be notified by letter of the intention to bring the worker to the Board for an examination (or consultation with a specialist).

The attending physician will be notified by the Adjudicator of any claims decision following the examination, and any changes in the status of the claim, unless matters of internal administration only are involved. The Board Medical Advisor is responsible for notifying the attending physician of any medical matters that should be brought to the physician's attention following the examination.

*#78.22 Consultation with Specialists*

In an accepted claim where treatment is continuing and no transportation costs for the worker are involved, no permission of the Board for a consultation is necessary. No consultation shall be charged to the Board unless the necessity for consultation in respect of the injured part has been shown on the referring doctor's reports.

Where transportation costs for the worker are involved, permission for the referral of a worker for consultation must be obtained from the Board.

Where the Board arranges a consultation with a specialist, the attending physician must be notified of the appointment. Where a Board Medical Advisor wishes to refer a worker to a consultant, it will, if practicable, first be discussed with the attending physician giving him or her an opportunity to express a preference as to the consultant.

When a consultation is authorized on an investigative basis for an opinion necessary for the adjudication or possible reopening of a claim, arrangements may be made for the examination of the worker at the Board prior to being seen by the specialist. This is at the discretion of the Board Medical Advisor. Where the validity of the claim has not yet been determined, it will be indicated to the specialist that no treatment or compensation benefits can be authorized until the decision has been made on the claim.

Board policy does not permit approval of surgery on an investigative basis. Investigative referrals for consultation or examination do not extend to invasive procedures that could result in a disability. Where surgery is being requested, and it is not felt the condition is a Board responsibility, the worker is advised that such surgery must be undertaken on a private-patient basis. The worker is also

advised that the Board will be prepared to review the surgical report to determine whether any Board responsibility does exist.

When the opinion of a consultant is being sought, the Adjudicator and the Board Medical Advisor are required to detail exactly the relevant medical questions which must be specifically addressed by the consultant. The instructions to the consultant are in writing.

When a worker has been referred to a specialist at the request of the attending physician with reference to diagnosis or treatment, a copy of the specialist's report will be sent to the attending physician by the specialist or the Board Medical Advisor. Similarly, when the worker is referred by a Board Medical Advisor to a specialist with reference to diagnosis or treatment, a copy of the specialist's report will be sent to the attending physician.

Decisions taken with regard to appropriate action upon receipt of the consultant's report will be the responsibility of the Board Medical Advisor with respect to treatment issues, and the responsibility of the Adjudicator with respect to adjudication issues.

*#78.23 Psychiatric Treatment and Consultation*

Where a psychiatric examination is being arranged, it will, in most cases, be on an investigative basis. Psychiatric treatment will not normally be authorized until a report has been received from the psychiatrist relating to diagnosis, etiology, treatment possibilities and prognosis.

*#78.24 Failure to Attend, or Obstruction of, Examination*

Before compensation can be suspended under Section 57(1) on the grounds of a failure to attend, or obstruction of, a medical examination, the following prerequisites must be satisfied:

1. There must be clear evidence that an appointment was made and that the date, time and place were communicated to the worker and that the worker did not advise, by letter or otherwise, that the arrangements for the examination were not convenient.

2. There must be clear evidence of obstruction.

3. The worker must be advised by the physician, in general terms, of the provisions of Section 57 and that the obstructive behaviour will be reported to the Adjudicator.

4. Should the worker persist in refusing to be examined or in obstructing the examination, the attempt shall be concluded and the matter referred forthwith to the Adjudicator.

5. The Adjudicator must advise the worker, in person, by telephone, or in writing, of the intention to apply Section 57(1), reasons for the intended action, and the worker must be given an opportunity to explain the refusal or obstruction.

6. Should an explanation not be forthcoming, or should it be deemed unsatisfactory by the Adjudicator, payment of benefits shall be suspended.

7. Should the worker not appear for the examination, the steps outlined in (5) and (6) above shall be undertaken.

8. Notice to the claimant of the suspension of benefits shall include notice of an appointment for a further examination and should advise that, should the worker attend and be examined on that occasion, benefits will be reinstated, however, without retroactivity.

Where a pension is instituted, the retroactive date of the pension should not automatically be the day following the date of wage-loss suspension. The effective date of the pension must be the date when it is deemed the worker's condition has stabilized.

## #78.30 Fees or Remuneration

The Board may contract with physicians, nurses, or other persons authorized to treat human ailments, hospitals, and other institutions for any health care required, and to agree on a scale of fees or remuneration for that health care. (19)

The fees of health care professionals are normally governed by fee schedules approved by the Board. These may be fees negotiated specifically by the Board or the Board may have decided to adopt the fee schedule of another agency such as the Medical Services Commission. Where there is not an approved fee schedule, the treatment and the fees payable must be approved in advance by the Board.

The fees or remuneration for health care furnished shall not be more than would be properly and reasonably charged the worker if personally paying, and the amount shall be fixed and determined by the Board, and no action for an amount larger than that fixed by the Board shall lie in respect of health care benefits. (20) The doctor is not permitted to bill the worker for any balance of the account regarding a compensable condition which the Board has not agreed to pay. If

the doctor does this, the Board reimburses the claimant, but deducts the amount from any future account the doctor submits to the Board.

Information regarding the current fee schedules of the Board for the professions and other suppliers of goods and services can be obtained by applying to the Board.

*#78.31 Adjudication of Health Care Benefits Accounts*

All accounts submitted to the Board for services and goods provided for injured workers are audited by the Health Care Benefits Department of the Board to ensure compliance with the Act and the fee schedules, and to ensure that the services or goods are appropriate to the worker's condition.

Where it is determined that services or goods supplied to a claimant are not related to a compensable condition, the supplier will be notified as soon as possible.

When a decision is made by a Board officer that a worker's ongoing problems are not considered compensable, this decision is conveyed in writing to all concerned, including individuals or facilities that submit treatment accounts. Regardless of the timing of the decision letter and the receipt of accounts, no accounts are payable for treatments after the date the worker is no longer deemed to be suffering from a compensable condition.

For a variety of reasons, the Board may decide to limit medical treatment even though the worker's ongoing complaints are considered to be compensable; for example, a denial of concurrent treatment (#74.60) or a denial of an extension of chiropractic treatment (#74.21) or physiotherapy (#75.12). When such limitations occur, the Board normally will pay accounts up to the date of the decision letter if the reports or accounts are submitted promptly and in good faith. If the practitioner, however, neglects to inform the Board of the treatment until some time after it is provided and by so doing delays the Board's decision, these accounts will not be paid.

All accounts should be submitted promptly at the conclusion of the transaction or treatment. Section 56(3) provides that "Unless the board otherwise directs, an account for medical services or health care must not be paid if it is submitted later than 90 days from the date that

(a) the last treatment was given; or

(b) the physician or person furnishing the medical service was first aware that the board may be liable for his or her services, whichever first occurs."

In applying this section, some degree of discretion is exercised. The general policy is that if a person has provided a medical service it should be paid for.

However, serious offenders may be notified of this requirement. If they continue their practice of late billing, their accounts may be rejected.

*#78.32 Reversal of Decision on Review or Appeal*

Where a claim, previously allowed, has now been disallowed, the Board will not initiate any steps to recover health care benefit payments already made; but if the Board is offered reimbursement by any other agency, the offer will be accepted.

Where accounts are outstanding at the time when the disallow decision is made, or are received after the decision, those accounts will not be paid, and the people rendering the accounts will be advised to submit them elsewhere. In these circumstances, the Board only declines to pay accounts for treatment, etc. Fees for reporting to the Board are still payable; so are the fees for any examination of the patient undertaken at the request of the Board for adjudication purposes.

Where a claim, previously disallowed, is now allowed, the Board will not at its own initiative solicit accounts for health care rendered prior to the date when the claim is allowed; but if accounts are received in respect of health care already rendered in respect of the compensable injury, and the Review Division or the Workers' Compensation Appeal Tribunal decision does not deal with the question of entitlement to that health care, the accounts are adjudicated as if the claim had been accepted in the first instance. The Board officer has, however, a discretion to pay for medical treatment or procedures undergone by the worker in good faith on the advice of his or her practitioner, even though the treatment or procedures might not ordinarily be approved for the worker's condition. The Board will not, under this policy, pay for treatment modalities or diagnostic procedures not generally recognized by the Board.

A copy of the Review Division or Workers' Compensation Appeal Tribunal decision reversing the previous decision is sent to the attending physician.

**EFFECTIVE DATE:** March 3, 2003 (as to references to the Review Division and The Workers' Compensation Appeal Tribunal)
**APPLICATION:** Not applicable.

*#78.33 Form Fees*

Where a claim is disallowed or suspended, and accounts submitted for treatment are not being paid, a form fee is paid in respect to any medical reports submitted prior to the date of the decision to disallow or suspend the claim.
Where a claim is rejected, that is, where:

1. a self-employed worker has no personal optional protection; or

2. the claimant was employed by an employer not covered under the Act; or

3. a report was submitted in error;

form fees are not normally payable. In the event of the unusual situation where a medical report had been requested by the Board and the claim is eventually rejected, the form fee will be paid.

**#79.00 CLOTHING ALLOWANCES**

The clothing allowances set out below are payable to upper and lower limb amputees wearing prostheses, and to workers wearing a leg brace. (21) The amputation must be at or above the wrist, or at or above the ankle. Effective July 1, 1993, the allowance is also payable to a worker confined to a wheelchair, who is not otherwise entitled, at the same rate as is payable to a lower limb amputee.

| - | **Single Upper Limb Amputee** | **Bilateral Upper Limb Amputee** | **Lower Limb Amputee or Requires a Leg Brace** | **Upper and Lower Limb Amputee** |
|---|---|---|---|---|
| July 1, 1998 - June 30, 1999 | $236.89 | $474.93 | $474.93 | $711.88 |
| July 1, 1999 - June 30, 2000 | 240.83 | 482.82 | 482.82 | 723.71 |
| July 1, 2000 - June 30, 2001 | 245.86 | 492.91 | 492.91 | 738.83 |
| July 1, 2001 - June 30, 2002 | 254.61 | 510.45 | 510.45 | 765.12 |

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

Effective January 1, 2008, the amounts of the clothing allowances will be adjusted on January 1 of each year. The Board determines the percentage change to be applied annually to these amounts by comparing the percentage change in the consumer price index for October of the previous year with the consumer price index for October of the year prior to the previous year.

Payment of the allowance is automatically made by virtue of the amputation. Proof is required neither of the wearing of the prosthesis or prostheses nor of the replacement, repair, or damage to clothing. Payment in the case of leg braces is contingent on the continued wearing of the apparatus.

Entitlement to this allowance commences as of the date of the amputation or the worker's commencing to use the brace or wheelchair. Payment is made by separate cheque on January 1st of each year. This is a full calendar year payment which covers the year of payment. The first payment is made on the January 1st following the initiation of pension payments and this first payment will include any retroactive entitlement for prior periods of disability not previously paid.

Payment of this clothing allowance is withheld while a worker is in prison. The amount withheld is paid to the worker on release if the period in prison was less than one year. If the period in prison is more than one year, the clothing allowance is not paid for each full year the worker was in prison.

**EFFECTIVE DATE:** October 1, 2007 – Revised to change the reference to the date of clothing allowance adjustments from July to January 1st of each year.
**APPLICATION:** Applies on or after October 1, 2007

## #80.00 PERSONAL CARE EXPENSES OR ALLOWANCES

In cases of major injuries, such as spinal cord injuries, resulting in paraplegia or quadriplegia, severe head injuries, hemiplegia, aphasia, near or total blindness, multiple amputations, or severe disability as a result of occupational diseases, the Board may pay certain personal care expenses. These expenses are in addition to wage-loss or pension benefits.

Personal care expenses may be paid when a seriously disabled person, though not confined to an institution, has very limited mobility or requires assistance in toilet functions, bathing, eating, or has other problems in caring for himself or herself, or needs assistance to a lesser or greater degree in daily living. Personal care expenses are payable at the discretion of the Board. An investigation is made of the circumstances of each case.

While aimed primarily at situations where there is severe permanent disability, in limited situations personal care expenses may also be paid in cases of severe temporary disability. Before making temporary payments, consideration is given to such factors as the worker's home and family situation, geographical location, the medical condition and other relevant difficulties.

In lieu of the actual personal care expenses incurred by the worker, the Board may pay a flat rate personal care allowance determined in accordance with the principles set out in #80.10 and #80.20 below.

The payment of personal care expenses or allowances will cease upon the death of the worker.

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### #80.10 Levels of Personal Care Allowances

There are five levels of personal care allowances:

**Level 1**: The claimant has restricted mobility but can feed, partly cleanse and otherwise care for himself or herself but does need some assistance in acts of daily living.

Examples are:
Blindness or near blindness, multiple amputations at or above the wrist or ankle, aphasia, hemiplegia, or any permanent disability resulting in a loss of function of the limbs, but not to an extent that significantly impairs other body functions.

**Level 2**: Restricted mobility. Claimant can feed, clothe and wash himself or herself but needs assistance in other aspects of personal care and acts of daily living.

This includes:

Paraplegia with bowel and bladder functions impaired.

**Level 3**: Restricted mobility. Claimant needs ongoing assistance in washing, shaving, dressing, feeding, precautionary attention to skin care and ongoing assistance in daily living.

Examples are:
1. Severe head injury resulting in brain damage to the extent that the claimant is not bedridden, but is dependent upon assistance and ongoing care.
2. Quadriplegia with impairment of bowel and bladder functions.

**Level 4**: Claimant is almost totally immobile and requires extensive assistance in maintaining personal hygiene, precautionary attention to skin care and ongoing assistance in all phases of daily living.

Examples are:
High lesion quadriplegia or severe head injuries.

**Level 5**: The claimant is totally immobile for all practical purposes and essentially requires assistance in all phases of personal hygiene, body functions and acts of daily living (quadriplegic, decerebrate and bedridden).

The determination of whether a personal care allowance is applicable and the appropriate level may include consideration of factors such as home and family situation, geographic location and other difficulties that may be encountered in relating to the claimant's environment. Other medical conditions that may not be a direct result of the personal injury sustained may also be considered in the determination.

Personal care allowances may be adjusted up or down in the event that the circumstances following the original application substantially change.

## #80.20 Amounts Payable at Each Level

The amounts of personal care allowances are set out below.

| | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| January 1, 1999–December 31, 1999 | | | | | |
| Daily Amount | 12.38 | 21.09 | 31.37 | 40.62 | 50.09 |
| Monthly Amount | 372.64 | 651.96 | 941.68 | 1,221.00 | 1,500.62 |
| January 1, 2000–December 31, 2000 | | | | | |
| Daily Amount | 12.66 | 21.57 | 32.09 | 41.55 | 51.24 |
| Monthly Amount | 381.19 | 666.91 | 963.27 | 1,249.00 | 1,535.03 |
| January 1, 2001–December 31, 2001 | | | | | |
| Daily Amount | 13.01 | 22.17 | 32.98 | 42.71 | 52.66 |
| Monthly Amount | 391.79 | 685.45 | 990.06 | 1,283.72 | 1,577.71 |
| January 1, 2002–December 31, 2002 | | | | | |
| Daily Amount | 13.26 | 22.60 | 33.62 | 43.53 | 53.67 |
| Monthly Amount | 399.31 | 698.61 | 1,009.07 | 1,308.36 | 1,608.00 |

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

After January 1, 1993, the amounts of the personal care allowances will be adjusted on January 1 of each year. The Consumer Price Index ratio determined under Section 25 of the *Workers Compensation Act* for January 1 and the previous July 1 will be used (see #51.00).

## #80.30 Payment Procedure

Where the Board is paying the worker's actual expenses, it may pay directly the account of a company registered to provide the required assistance. The Board does not pay a personal care allowance directly to an individual attendant.

In a case where the worker is receiving a flat rate allowance or has hired an individual attendant, the amount is paid directly to the worker if he or she is capable of money management.

Once approved, personal care allowances are normally paid monthly. The worker, or the person providing the care, is required to complete and sign the prescribed form and return it to the Board each month, or at such other intervals as may be determined by the Board.

## #80.40 Claimant Requires Institutional Care

The payment of personal care expenses or allowances will be suspended if the claimant is institutionalized for more than fourteen calendar days, but may be reinstated upon returning home.

If a claimant is totally disabled and requires ongoing institutional care as a result, a flat rate personal care allowance will not be paid. The Board provides the cost of institutional care as part of the health care benefit program. If it appears that such a claimant can be provided the same kind of nursing or custodial care outside an institution, the Board may, as an alternative to paying personal care allowance, pay an amount calculated, at least in part, by reference to the cost of institutional care.

## #81.00 INDEPENDENCE AND HOME MAINTENANCE ALLOWANCE

Normally, most workers who are homeowners have the physical capacity to maintain their property in order to protect their investment in home and property. Such things as painting, repairing, landscaping, appliance repairs, renovations and the many other activities required to maintain the home are difficult or impossible for the disabled. The severely disabled claimant is usually required to hire tradespersons or others to carry out these activities, thereby incurring additional costs for maintaining home and property.

Similarly, the disabled claimant may not have the physical capacity to maintain and/or drive a car or to use public transportation, and is consequently required to hire taxis or other forms of transportation to enjoy a reasonable degree of independence.

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In order to assist in these and similar kinds of expenses, the Board has established a category of assistance separate and distinct from personal care allowances, called the independence and home maintenance allowance. This allowance may be paid over and above any level of personal care allowance and is in addition to any wage-loss or pension benefits.

Effective September 1, 1992, the criteria for paying the independence and home maintenance allowance are as follows:

1. The worker must have sustained a permanent compensable disability which meets one of the following criteria:

   (a) The disability measured using the physical-impairment method of assessment is equal to 75% of total or greater.

   (b) The disability measured using the projected-loss-of-earnings method of assessment is equal to an equivalent of 75% of total or greater and it is concluded, after obtaining the advice of the Vocational Rehabilitation Consultant, that the disability will prevent the worker from carrying out the activities covered by the allowance.

   (c) The compensable disability is superimposed on another permanently disabling medical condition, whether compensable or not, and the combined disability meets (a) above or the Board grants a projected-loss-of-earnings award which meets (b) above. Where the pre-existing disability is non-compensable, the compensable disability must be at least half the combined disability measured using the physical-impairment method of assessment and be a significant factor in the worker's inability to do the activities covered by the allowance.

2. The worker must maintain a home or live in rented accommodation. A worker who lives in a nursing hospital or extended care facility will not be eligible. Other accommodation may be approved if it can be concluded that the worker would have contributed to its maintenance had the disability not occurred.

3. If the worker is institutionalized in a hospital, nursing care facility or extended care facility, but the spouse and children continue to maintain the family home, the allowance may be paid to the spouse.

4. The allowance commences as of the date when the worker meets the criteria set out above and will be terminated upon the death of the worker or if the worker ceases to meet the above criteria. The allowance may be paid retroactively if time elapses between the date of the worker becoming eligible for the allowance and the date eligibility is determined. With regard to any period prior to September 1, 1992, no payment can be made unless the worker meets the criteria which existed prior to that date. (22)

The independence and home maintenance allowance is payable at the discretion of the Board. The circumstances surrounding each case will be reviewed by the Rehabilitation Consultant who will provide a report and recommendations.

Once the allowance is approved, the worker or spouse is required to complete and sign the appropriate form and submit it each month, or at such other intervals as may be determined by the Board.

The amount of the independence and home maintenance allowance is set out below.

| Date | Monthly Amount |
|---|---|
| January 1, 1999 – December 31, 1999 | $196.99 |
| January 1, 2000 – December 31, 2000 | 201.51 |
| January 1, 2001 – December 31, 2001 | 207.12 |
| January 1, 2002 – December 31, 2002 | 211.09 |

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

After January 1, 1993, the amount of the independence and home maintenance allowance will be adjusted on January 1 of each year. The Consumer Price Index ratio determined under Section 25 of the *Workers Compensation Act* for January 1 and the previous July 1 will be used (see #51.00).

The independence and home maintenance allowance is not retroactive to before June 13, 1980, but, subject to the claimant's qualifying as above described, the allowance is paid regardless of date of injury or permanent disability due to occupational disease.

## #82.00 TRANSPORTATION ALLOWANCES

Section 21(1) authorizes the Board to furnish or provide the injured worker with transportation it may deem reasonably necessary.

## #82.10 Eligibility for Transportation

Subject to the exceptions set out at the end of this item, return transportation expenses are normally reimbursed when:

1. A worker travels to a place of medical examination or treatment where the appointment has been previously approved by the Board or is subsequently paid for by the Board; or

2. A worker travels in connection with a vocational rehabilitation program where the travel is requested or approved as part of the program by the Vocational Rehabilitation Consultant; or

3. A worker is at the time of injury working at a place other than his or her place of residence and wishes to transfer to the place of residence and the disability from the injury prevents the worker from using the mode of transportation which he or she ordinarily would have used to do this; or

4. A worker meets the criteria set out in policy items #100.12 or #100.13 in connection with attendance at a claims or Review Division inquiry.

Transportation expenses are not normally paid in regard to:

1. Travel within the boundaries of a local bus service (including the area serviced by the Greater Vancouver Regional District transportation system) where the bus is a reasonable means of transportation for the worker.

2. The portion of any journey which takes place within a distance of 24 kilometres of the destination. This does not apply where the worker's condition is such as to require travel by:

   (a) ambulance; or
   (b) taxi, and the worker has received prior authorization for this from the Board.

3. The portion of any journey which takes place beyond the boundary of the province. This does not apply where the Board specifically requests the claimant to attend a medical examination, or in certain situations specified in policy item #100.15 in relation to claims or Review Division inquiries.

The Board may be ordered by the Workers' Compensation Appeal Tribunal to pay certain expenses. Section 7 of the *Workers Compensation Act Appeal Regulation* (B.C. Reg. 321/2002) provides that the Board may be ordered by the Workers' Compensation Appeal Tribunal to reimburse a party to an appeal under Part 4 of the *Act* for the following kinds of expenses:

- expenses associated with attending an oral hearing or otherwise participating in a proceeding, if the party is required by the Workers' Compensation Appeal Tribunal to travel to the hearing or other proceeding; and

- expenses associated with obtaining or producing evidence submitted to the Workers' Compensation Appeal Tribunal; and

- expenses associated with attending an examination required under section 249(8) of the *Act*.

However, the Workers' Compensation Appeal Tribunal may not order the Board to reimburse a party's expenses where those expenses arise from a person representing

the party or the attendance of a representative of the party at a hearing or other proceeding related to the appeal.

**EFFECTIVE DATE:** March 3, 2003 (as to references to the Review Division, the Workers' Compensation Appeal Tribunal and section 7 of the *Workers Compensation Act Appeal Regulation*)
**APPLICATION:** Not applicable.

*#82.11 Worker Bypasses Nearby Medical Facilities*

Claimants may, of their own accord, bypass adequate local treatment facilities to attend a practitioner of their own choice elsewhere. The *Workers Compensation Act* allows freedom of choice of physician or qualified practitioner by the injured worker. Obviously, there must be some limitation of the costs of such freedom. For example, a worker in Prince George could not reasonably insist that since the physician or qualified practitioner of her or his choice worked in Vancouver, there should, therefore, be reimbursement for transportation to and from Vancouver to seek this medical care.

If, however, necessary medical care is only available in a given centre, or the Board, acting on the advice of the health professional, refers a worker to another centre for medical care, the costs of transportation will be chargeable to the Accident Fund.

If a worker, by choice, bypasses adequate local treatment facilities, transportation costs will not be paid. Adequate treatment facilities in this case are defined as physicians or hospitals in all cases. Since all other "qualified practitioners" are limited in the types and extent of care they can offer, it would not be reasonable to prohibit a worker from bypassing one of those practitioners to get to the nearest hospital or doctor. On the other hand, it would be unreasonable to allow a worker to bypass a hospital or a doctor to go to a "qualified practitioner". (23)

A worker may, following the injury, move his or her place of residence to another location and thereby incur increased transportation costs. This may or may not be because the worker was injured while working away from home. The Board will not normally pay the cost of the move from one place of residence to another. It will, however, pay normal transportation costs for travel from the place where the worker resides to a place of treatment or examination in the worker's area of residence even though the worker's choice of place of residence results in greater transportation costs. The Board will not pay for travel from the place of residence to a doctor in the worker's former residence unless the worker's condition requires treatment by that particular doctor.

## #82.20 Amount of Reimbursement

The principles set out below apply with regard to expenses incurred in connection with a claim or Review Division inquiry.

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The Board will pay the cost of public transportation where this is available and is a reasonable and normal means of travel for the journey to be made by the worker. Where the Board consider it advisable, a worker will be encouraged to travel by air and the Board will assume the cost of the air fare, together with the cost of transportation to and from airports. In situations where air travel is acceptable and the worker elects to use some alternative means, such as the use of a private car, only the most reasonable and economical public transportation cost, which is usually the bus fare, will be reimbursed. Where air travel is not practical, and not approved, only the bus fare will normally be reimbursed irrespective of the method of travel utilized by the worker. The "bus fare" rate includes necessary meal costs and taxi costs to and from bus terminals.

Where public transportation is not reasonably available, the most economical method of transport that is reasonably available will be considered.

Taxi fares will be paid when medical reports indicate that the worker's condition does not permit travel by public transportation. The worker must first obtain prior Board approval and will be required, if no voucher is provided, to obtain receipts from the taxi driver and submit the receipts for a refund.

Where there is no public transportation available, or it is deemed otherwise reasonable and acceptable for the worker to drive his or her own vehicle, an allowance of 28 cents per kilometre is paid, effective January 1, 1997, for journeys meeting the minimum kilometre limit set out in #82.10. Prior to January 1, 1997, the allowance was paid as follows:

| **Date** | **Amount Per Kilometre** |
|---|---|
| January 1, 1999 - December 31, 1999 | 28¢ |
| January 1, 2000 - December 31, 2000 | 29¢ |
| January 1, 2001 - December 31, 2001 | 30¢ |
| January 1, 2002 - December 31, 2002 | 30¢ |

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

It may, for example, be considered reasonable for a worker to drive his or her own vehicle where there is available public transport if the bus journey would involve multi bus transfers or coming by automobile would be acceptable where it permits the worker to put in half a day at work and still keep an appointment. Parking fees are payable if parking charges are levied by the hospital or medical building where the worker is attending for treatment, but are only paid where approval has been given to pay a kilometre allowance.

After January 1, 1993, the kilometre rate will be adjusted on January 1 of each year. The Consumer Price Index ratio determined under section 25 of the *Act* for January 1

and the previous July 1 will be used (see policy item #51.00). The result is rounded to the nearest cent.

Where a worker has voluntarily moved out of the province, eligible expenses are normally limited to what would be paid if the expenses were incurred in British Columbia. Where travel costs are being paid, the cost of travel back to British Columbia (usually the air fare) is prorated on a kilometre basis and the payment covers only the percentage of the travel occurring in British Columbia.

Parking fees may be payable where approval has been given to pay a kilometre/mileage allowance.

Where a worker has to buy meals while engaged in a journey for which the Board is paying expenses, the Board will pay the rates set out in policy item #83.20.

Flat rate travel allowances to cover the cost of different forms of transportation from different starting points to different destinations may be established. This includes situations where part of the journey takes place outside the province. These allowances should cover the normal cost of the journey in question including incidental costs such as parking, taxi, airporters, and meals which will usually be incurred in the journey. The amount of the allowance may be paid to the worker in place of actual expenses.

The worker in receipt of a flat rate payment may request reimbursement of actual expenses if, because of exceptional circumstances, expenses are incurred which are significantly higher than the amount of the flat rate. These expenses would have to meet the normal criteria for payment set out in this part of the manual.

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

## #82.30 Manner of Payment

Air travel is normally arranged through a travel agency used by the Board.

Travel arrangements may also be made by forwarding a cheque to the worker in advance of the scheduled trip. Normally, such advance payments will only be paid at the rate of the bus fare. In any exceptional situation where the cheque forwarded to the worker is to cover an air fare, but the worker elects to use other transportation that is less expensive, the Board will not ask for a refund of the difference in cost.

Where an advance payment has been made and the worker does not keep her or his appointment and another appointment cannot be arranged, the worker will be asked to return any transportation expenses that have been advanced. They will be treated as an overpayment. (24)

## #82.40 Transportation Provided by the Employer

Every employer shall, at its own expense, furnish to a worker injured in its employment, when necessary, immediate conveyance and transportation to a hospital, physician or qualified practitioner for initial treatment. (25) After such initial treatment, the Board provides any necessary transportation.

In the event a doctor is called to the scene of the accident, the employer shall be responsible for any charge made by the doctor with respect to mileage or travelling time. Where air transportation is utilized, stretchers suitable for use in planes shall be provided.

The transportation of an injured fisher to a hospital or physician or qualified practitioner is discussed in Fishing Industry Regulation 13 (found in Workers' Compensation Reporter Decision 223).

## #82.50 Flight Changes

Because of advance bookings, flight reservations made by the Board are normally at a preferred rate.

A worker may change a flight reservation or elect to fly after having previously advised that he or she will use some other means of transportation. This may result in increased flight cost. The Adjudicator will investigate the reasons for the change. If the investigation establishes that the change was necessitated for some emergency or other unavoidable reason, the Board will pay the costs incurred. If, however, it is shown that the change was due to a personal choice or preference on the part of the worker, the worker will either not be entitled to reimbursement of the additional costs incurred or may be required to reimburse that amount to the Board. The latter may be accomplished through a deduction from future wage-loss entitlements.

Claimants scheduled to travel by air are advised in advance of this policy.

## #83.00 SUBSISTENCE ALLOWANCES

The Board may make a daily allowance to an injured worker for subsistence when, under its direction, the worker is undergoing treatment at a place other than the place of residence. The power of the Board to make a daily allowance for subsistence extends to an injured worker who receives compensation, regardless of the date of first becoming entitled to compensation. (26)

## #83.10 Eligibility for Subsistence

Subsistence may be paid where a journey, for which the Board is paying transportation expenses (see #82.10), requires the worker to spend one or more nights away from home. It may continue to be paid for the duration of a treatment or vocational rehabilitation program which has been approved by the Board, and which requires the worker to spend a period of time away from home.

In determining whether a journey or program requires a worker to stay from home overnight, regard will be had to whether the worker can travel from home and return daily for a cost less than the amount that would be paid for subsistence.

Unless maintaining a connection to a place other than where the Board has directed the worker to be, no subsistence payments will be made. Maintaining a connection means paying a significant amount of rent, mortgage, or other fee or cost that guarantees a place for the worker to live upon return.

Where a worker is maintaining a residence close to work and also has a residence in another place, subsistence will not be paid while receiving treatment in either place. This is so even though the employer provides an allowance to cover the cost of the residence close to the work place and this ceases while the worker is disabled. However, the amount of the allowance is treated as part of the worker's earnings for the purpose of computing wage-loss benefits. (27)

No subsistence is payable where a worker receives accommodation at the Board's Rehabilitation Residence. This is so even though the worker elects to visit home or leave the Residence for some other purpose at a weekend. The Board will provide Residence accommodation to workers eligible for admission (28) who are not maintaining a connection to a place but who have been directed to travel to Richmond by the Board. In these cases, there will be no subsistence paid in lieu of Residence privileges.

Residence accommodation or subsistence is not available to workers who, at their own choice, simply choose to travel to Vancouver or any other centre for treatment or to await recovery.

### *#83.11 Travelling Companions*

The following general rules will apply with regard to subsistence payments and Residence accommodation for travelling companions, attendants or visitors for injured workers. Reimbursement of costs for persons other than the worker does not include any wage or income loss incurred.

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1. Where it is medically necessary, the Claims Adjudicator will authorize subsistence payments or Rehabilitation Residence accommodation for one night for a travelling companion to take a patient to a treatment centre, medical examination or meeting in any city where it is not reasonable to expect the travelling companion to return home that day. Another night may be allowed to accompany the patient home if he or she is required to stay more than one day at that centre and a travelling companion is medically necessary in the opinion of the Adjudicator. (In case of emergency, other designated Board officers may authorize travel and subsistence.) Where it is not necessary for the travelling companion to stay overnight, travel costs and appropriate meal allowances will be paid.

2. Where an injured worker is in critical condition in a hospital, a spouse, relative or other person from the worker's residence with a close attachment to the injured worker may receive transportation costs, subsistence payments or Residence accommodation as long as the worker remains in critical condition.

3. Where an injured worker has sustained a major amputation and the presence of a spouse or parent is deemed advisable, the spouse or parent may receive transportation costs, subsistence payments or residence accommodation to visit with the injured worker, during the early stages of treatment and the fitting of a prosthesis in the Rehabilitation Centre.

   Approval for these visits is recorded on the claim and requires approval from the Amputee Group Physician and the Manager of the Rehabilitation Centre[1] or their delegates.

4. Where under Board sponsorship or direction a worker is undergoing a period of treatment or retraining which requires the worker to live elsewhere than her or his normal residence for a period of six weeks or more, the Adjudicator will, on not more than one occasion every three weeks pay for a visit home by the worker or, in lieu of this, authorize subsistence payments or Residence accommodation for up to two nights plus transportation costs for a spouse, relative or other person from the worker's residence with a close personal attachment to the worker visiting the worker. Where the trip involves travel outside of British Columbia, the Board will prorate the airfare on a mileage basis and only pay the portion from the British Columbia border. This proration may, at the discretion of a Director in the Compensation Services Division, be waived in the case of a spouse, relative or other person from the worker's residence with a close attachment to the injured worker who is visiting a worker in critical condition in a hospital.

[1] The "Claims Department" no longer exists.

The payment of transportation costs includes the costs of meals where necessary. Any visit home not meeting the above criteria must be at the worker's own expense. No subsistence allowances will be paid if a worker elects not to return home but lives elsewhere than the Residence over a weekend.

5. Where the Adjudicator feels that there are other circumstances where subsistence or Residence accommodation for a person with a close attachment to the injured worker is appropriate, one night may be allowed and the reason for so doing noted on the claim with a copy sent to a Director in the Compensation Services Division. Where a longer stay is felt to be appropriate, the Adjudicator may request subsistence or Residence privileges from a Director in the Compensation Services Division. In these cases, the reasons and the claim should be forwarded for decision but this requirement may be dispensed with at the discretion of a Director in the Compensation Services Division.

6. Where a spouse attends a chronic pain clinic at which the claimant is being treated, travelling expenses and subsistence allowances are payable.

The Claims Adjudicator will normally accept the judgment of the attending physician as to whether a travelling companion should accompany the claimant or whether the worker's condition is considered critical.

*#83.12 Visits Home by Worker*

Where under Board sponsorship, a worker is undergoing a program of retraining away from her or his residence and the course of retraining is one of six weeks or more duration, the same provisions as listed in #83.11, item 4 apply.

*#83.13 Income Loss*

In situations where a worker who is not deemed disabled from working loses time from work to attend treatment or examination by a physician or qualified practitioner or for other authorized treatment, a payment through health care benefit funds can be made. These situations will either involve a worker who has never been declared disabled as the result of the injury or occupational disease, or has returned to work following a period of disability, but is still undergoing treatment. The payment is normally equal to 75% of the worker's actual current loss. However, it is subject to the same rules as to the maximum and minimum as are applicable to temporary total disability benefits. (See #34.20 and #69.00.)

Such payments are made where it is deemed unreasonable for the worker to attend for the examination(s) or treatment(s) outside of working hours. Generally, there will be no reimbursement if the loss incurred is under two hours, however, multiple losses, which in the aggregate accumulate to a significant loss,

may qualify for payment. While these payments are not wage-loss compensation, the provisions of Section 5(2) of the *Workers Compensation Act* will be followed. As such, no income-loss subsistence will be paid for losses incurred on the day of the injury.

If a loss is due either to the worker's personal selection of a physician or qualified practitioner which involves bypassing closer treatment facilities, this will be taken into account when evaluating an entitlement to income-loss subsistence.

In situations where the worker is maintained on full salary by the employer and an entitlement to income-loss subsistence has accrued, the payment will be made to the employer under the terms of Section 34 of the *Workers Compensation Act*.

## #83.20 Rates of Subsistence

"Subsistence" means the costs of accommodation and meals.

The Board will normally reimburse actual accommodation costs. (In the case of visits to Richmond, workers will be accommodated in the Richmond Residence.) When contacting the worker prior to departing from home, the Board officer will reach an agreement with the worker regarding the accommodation to be selected and the amount the Board is prepared to approve as a reimbursement.

In addition to accommodation costs, the worker will be paid a full or partial per diem meal allowance as follows:

| Date | Breakfast | Lunch | Dinner | Per Day |
|---|---|---|---|---|
| January 1, 1999 - December 31, 1999 | $9.23 | $11.38 | $19.57 | $40.20 |
| January 1, 2000 - December 31, 2000 | 9.44 | 11.64 | 20.02 | 41.13 |
| January 1, 2001 - December 31, 2001 | 9.71 | 11.96 | 20.57 | 42.27 |
| January 1, 2002 - December 31, 2002 | 9.89 | 12.19 | 20.96 | 43.04 |

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

The above meal rates also apply where a worker has to buy meals while engaged on a journey for which the Board is paying expenses.

Where board and/or room is included in a treatment or vocational rehabilitation program, it will be paid at cost.

The rate of subsistence in Richmond when claimants or other persons eligible for admission to the Board's Rehabilitation Residence choose not to stay there is as follows:

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| Date | Amount Per Day |
|---|---|
| January 1, 1999 - December 31, 1999 | $16.31 |
| January 1, 2000 - December 31, 2000 | 16.68 |
| January 1, 2001 - December 31, 2001 | 17.14 |
| January 1, 2002 - December 31, 2002 | 17.47 |

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

After January 1, 1993, the meal allowance, and the subsistence rate paid to workers who choose not to stay at the Residence, will be adjusted on January 1 of each year. The Consumer Price Index ratio determined under Section 25 of the *Workers Compensation Act* for January 1 and the previous July 1 will be used (see #51.00).

The rules set out above apply equally to family members or other persons travelling with or visiting an injured worker. The Board may, however, pay the cost of hotel accommodation for such a person close to the hospital where the worker is located even though there is accommodation available at the Residence. This would normally be limited to situations where the worker's condition is considered to be life threatening.

### #84.00 REHABILITATION RESIDENCE

The Board's Rehabilitation Residence is located at 6951 Westminster Highway, Richmond, British Columbia.

### #84.10 Eligibility For Admittance

As the Rehabilitation Residence is a self-care unit, the residents must normally be able to function by themselves, handle their own hygiene and keep their rooms tidy. Six rooms have however been modified for claimants who are paraplegics or suffer severe walking disabilities. These persons must be self-sufficient to the degree that, with or without the assistance of an authorized travelling companion, they could stay in an hotel.

The eligibility of claimants from outside the province for admission to the Rehabilitation Residence is the same as claimants from within the province.

The following categories for Residence admission eligibility have been established.

*#84.11 Rehabilitation Centre Treatment*

Any claimant who normally resides outside the Lower Mainland area and is taking treatment at the Board's Rehabilitation Centre is entitled to stay in the Residence. Injured workers who live in the Lower Mainland area, but for medical reasons might appropriately be admitted to the Residence, may be admitted at the discretion of the Claims Adjudicator where the Rehabilitation Centre Physician agrees. Discharge from the Rehabilitation Centre generally terminates Residence eligibility. The Residence staff has discretion to extend the stay a few days if travel connections prevent an immediate return home.

From time to time a Rehabilitation Centre patient is discharged to await further acute care in a hospital or a medical specialist consultation. This waiting period should be done at home rather than in the Residence unless the wait for the next service is known to be less than one week. This guideline is subject to the Adjudicator's discretion if:

1. the costs of travel are high;

2. the consequences of missing an important appointment are too great; or

3. travel arrangements are difficult.

For the purpose of this chapter, the Lower Mainland area extends to and includes Vancouver, Richmond, Delta, Surrey, New Westminster, Coquitlam, Port Coquitlam, Burnaby, North and West Vancouver, Deep Cove, Port Moody, White Rock, Haney, Maple Ridge, Whalley, Langley, and up to the eastern municipal boundaries of Abbotsford and Mission. It also includes all settlements and small villages, etc. inside this area.

## #84.12 Medical Consultation or Disability Evaluation

Injured workers can be admitted to the Board's Rehabilitation Residence for short stays when they have been sent to Richmond for a medical consultation or a permanent disability evaluation. A claimant should not be kept in the Residence any longer than five days for a medical examination unless the next medical visit is already scheduled. If the next medical visit is more than 10 days from the last visit, the claimant should return home to await the consultation.

This guideline is subject to the Adjudicator's discretion on the same grounds as are set out in #84.11.

Where a claimant involved in an appeal to a Medical Review Panel is entitled to subsistence in accordance with #100.13 Residence accommodation may be provided instead.

## #84.13 Rehabilitation Programs

Claimants brought to Richmond by a Rehabilitation Consultant are eligible for accommodation in the Board's Rehabilitation Residence in the situations set out below.

A. Rehabilitation Centre Vocational Assessment Programs

A claimant may be admitted to the Rehabilitation Centre for vocational evaluation, functional appraisal, and physical evaluation assessment as a rehabilitation procedure. In some instances, the worker may not be taking treatment other than in the industrial shops. The Rehabilitation Consultant can have such a worker admitted to the Board's Rehabilitation Residence.

B. Training and Education Programs

Claimants from outside the Lower Mainland area who have been placed in training positions or educational programs may be authorized to stay in the Board's Rehabilitation Residence by the Rehabilitation Consultant. The maximum length of stay is normally one month but extensions may be authorized by a Director, Claims or a delegate.

## #84.14 Rehabilitation Residence Filled

Where all the rooms at the Board's Rehabilitation Residence are filled, the Board provides hotel accommodation for claimants who would otherwise be eligible for admission. The practice set out in #83.20 is followed.

Claimants are allowed a maximum of two local telephone calls per day as part of their hotel account. No responsibility is accepted for long distance calls.

## #84.20 Right of Eligible Workers to Choose Own Accommodation

Patients are allowed a free choice as to whether they wish to stay at the Board's Rehabilitation Residence or stay elsewhere. Where it is the opinion of the treating doctor that residence elsewhere would be detrimental to the health of the patient, the patient will be advised to stay at the Residence and be informed of the medical opinion. But the patient will still be allowed the choice.

Where a patient who is eligible for accommodation at the Residence chooses to stay elsewhere (otherwise than at home), the subsistence allowance set out in #83.20 is payable.

Patients who live outside the Lower Mainland area, (29) but within the Fraser Valley, who come to the Rehabilitation Centre for treatment daily, will be offered accommodation at the Residence. If they elect not to accept that accommodation, they will be offered their actual travel expenses up to a maximum equal to the rate of subsistence payable under #83.20 to a worker who is eligible to stay in the Residence

but chooses not to do so. The use of automobiles will be permitted where it is unreasonable to expect the patient to use public transport.

Patients are not allowed to park campers or trailers on the Board's premises while attending the Rehabilitation Centre for the purpose of accommodating themselves or their families. The vehicle should be parked at a recognized trailer park and the claimant will receive the appropriate subsistence allowance if he or she chooses to live there.

## #84.30 Visits to and from Home

The eligibility of spouses, relatives, or companions of workers to receive subsistence and stay at the Board's Rehabilitation Residence is dealt with at #83.11.

No accommodation at the Residence will normally be offered to anyone under 16 unless a patient.

Where a spouse, relative, or other companion is not eligible for accommodation at the Residence under the guideline set out in #83.11, they will still be able to obtain accommodation by paying the current rate.

Where the Board is not paying for a spouse etc. to visit the patient in Richmond, (30) the Board will pay for one home visit every three weeks by the patient in accordance with the principles set out in #83.12.

## #84.40 Conduct of Worker at the Rehabilitation Residence

The Residence Manager has the responsibility for judging the conduct of claimants in the Residence. Disregard of the regulations of the Residence and caution against repetition can lead to loss of Residence privileges. This is a decision of the Manager in consultation with the Director, Technical Services. The worker may still, however, be entitled to a subsistence allowance.

## #84A.00 HOMEMAKERS SERVICES

The Board provides homemakers' services for cases involving a single parent or, in families with two parents, when one parent is incapable of maintaining the home and family due to illness or other reasons.

Normally, in such circumstances, arrangements have been made by the worker to look after home and family with live-in housekeepers/babysitters, daycare centres or other family or community resources while the worker is away on the job. It is assumed that the same or similar arrangements would continue as an ongoing personal responsibility even though the worker is attending treatment for an industrial injury or undergoing a vocational rehabilitation program rather than being at work.

## APPENDIX A

Homemakers' services may also be provided to workers where the seriousness of the injury would otherwise require hospitalization.

The Board does, however, recognize cases in which the provision of homemakers' services on a temporary basis should be considered, particularly in instances where a worker is away overnight. The Board will pay for such services under appropriate circumstances.

The criteria for the payment of a homemakers' service will be:

1. no suitable arrangements can be made with the family, friends, or through the use of community resources;
2. the decision for treatment outside the claimant's home environment should be a decision with which the Board is in agreement;
3. the rates paid for such service will not be in excess of reasonable community rates; and
4. in cases of emergency when the spouse escorts a seriously injured worker who must be transported immediately to another health care facility, thereby leaving the home and family unattended.

Homemakers' services are considered a health care benefit expense where the costs incurred are the result of treatment. Where the homemakers' services relate to a vocational rehabilitation program, the costs will be part of Vocational Rehabilitation Services. In all cases, the Vocational Rehabilitation Consultant is responsible for the investigation of the worker's circumstances and ongoing monitoring.

The allowance will normally be paid to the claimant.

**APPENDIX A**

# NOTES

(1) S.6(1); See #26.30
(2) See #75.11
(3) See #78.22
(4) S.1
(5) S.56; See #95.00
(6) S.56(2); See #78.00
(7) S.56(4)
(8) S.21(2)
(9) See #78.20
(10) See #74.60
(11) See #77.00
(12) See #78.20
(13) See #73.10
(14) See Chapter 16
(15) S.21(9)
(16) S.21(6)
(17) S.21(6)
(18) See #22.11
(19) S.21(6)
(20) S.21(6)
(21) See #80.00
(22) Decision 324
(23) See #74.00 for the difference between "physician" and "qualified practitioner"
(24) See #48.40
(25) S.21(3)
(26) S.21(1)
(27) See #71.21
(28) See #84.10
(29) See #84.11
(30) See#83.11

WORK SAFE BC

**REHABILITATION SERVICES & CLAIMS MANUAL**

| RE: Health Care – Introduction | ITEM: C10-72.00 |
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# BACKGROUND

**1. Explanatory Notes**

**This policy defines key terms and sets out general principles regarding a worker's entitlement to health care.**

**2. The Act**

**Section 1:**

> **"compensation" includes health care;**
>
> **"health care", when used in Part 1, includes the things which the board under this *Act* is empowered to provide for injured workers;**
>
> **"specialist" means a physician residing and practising in the Province and listed by the Royal College of Physicians and Surgeons of Canada as having specialist qualifications;**

**Section 5(2):**

> **Where an injury disables a worker from earning full wages at the work at which the worker was employed, compensation is payable under this Part from the first working day following the day of the injury; but a health care benefit only is payable under this Part in respect of the day of the injury.**

**Section 6(1):**

> **Where**
>
> **(a) a worker suffers from an occupational disease and is thereby disabled from earning full wages at the work at which the worker was employed or the death of a worker is caused by an occupational disease; and**
>
> **(b) the disease is due to the nature of any employment in which the worker was employed, whether under one or more employments,**

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

**Section 21(1):**

**In addition to the other compensation provided by this Part, the board may furnish or provide for the injured worker any medical, surgical, hospital, nursing and other care or treatment, transportation, medicines, crutches and apparatus, including artificial members, that it may consider reasonably necessary at the time of the injury, and thereafter during the disability to cure and relieve from the effects of the injury or alleviate those effects, and the board may adopt rules and regulations with respect to furnishing health care to injured workers entitled to it and for the payment of it. The board may make a daily allowance to an injured worker for the worker's subsistence when, under its direction, the worker is undergoing treatment at a place other than the place where he or she resides, and the power of the board to make a daily allowance for subsistence under this section extends to an injured worker who receives compensation, regardless of the date the worker first became entitled to compensation.**

# POLICY

## 1. DEFINITIONS

**In addition to the terms defined in the *Act*, the following terms, defined by the Board, are used throughout this Chapter:**

**"Activities of daily living" are basic activities that are performed by individuals on a daily basis for self-care. Examples include, but are not limited to: ambulating (e.g. walking), transferring (e.g. getting from bed to chair and back), feeding, dressing, personal hygiene (e.g. bathing, grooming, bladder and bowel care), and taking medication.**

**"Health care" may include, but is not limited to, the following:**

- **services provided by physicians, qualified practitioners and other recognized health care professionals;**
- **services provided by a health care facility;**
- **prescription medications;**

- **modifications to a person's home or vehicle;**
- **medical supplies, equipment, devices and prostheses;**
- **certain transportation and subsistence costs associated with obtaining health care; and**
- **additional benefits for severely disabled workers.**

**"Health care account" means a statement of fees owed for goods and/or services supplied, which a physician, qualified practitioner or other recognized health care professional submits to the Board (including reporting or form fees) for health care provided to a worker.**

**"Health care facility" means a hospital; surgical facility; office of a physician, qualified practitioner or other recognized health care professional; group home; or other place where acute, intermediate or long-term health care services or programs, are provided.**

**"Instrumental activities of daily living" are activities related to independent living. Examples include, but are not limited to: using a telephone, preparing meals, performing housework, shopping for groceries or personal items, managing medication, managing money, using public transportation, and maintaining and/or driving a car.**

**"Other recognized health care professionals" are health care professionals, other than physicians and qualified practitioners, recognized by the Board through contracts and/or fee schedules, to provide health care to injured workers, such as acupuncturists, audiologists, community health workers, denturists, dietitians, massage therapists, nurses other than nurse practitioners, occupational therapists, opticians, optometrists, physiotherapists, prosthetists and orthotists, pharmacists, psychologists, and other mental health care providers.**

**"Residence" means the place where a worker lives or regularly stays. Where the worker has more than one residence, the worker is required to identify one as the primary residence.**




## 2. GENERAL PRINCIPLES

### 2.1 Objectives

**The Board's objective is to provide reasonably necessary health care to cure, relieve or alleviate the effects of a compensable personal injury, occupational disease or mental disorder. In order to meet this objective, the Board aims to:**

- **facilitate the timely delivery of treatment;**
- **ensure that health care provided is appropriate and safe;**
- **ensure that injured workers receive quality care and services from physicians, qualified practitioners and other recognized health care professionals;**
- **work collaboratively with injured workers and their physicians, qualified practitioners and other recognized health care professionals in the development of treatment and rehabilitation plans;**
- **promote safe and early recovery and return to work;**
- **balance the individual needs of injured workers and the need to ensure the financial integrity of the workers' compensation system;**
- **support the long-term health care needs of severely disabled workers; and**
- **ensure that the health care provided is supported by up-to-date scientific evidence and information.**

### 2.2 Duration of Entitlement to Health Care

**On accepted personal injury and mental disorder claims, entitlement to health care begins on the date of injury. On accepted occupational disease claims, entitlement to health care begins on the date the worker first seeks treatment by a physician, qualified practitioner or other recognized health care professional.**

**Health care continues for as long as the Board considers it reasonably necessary with respect to the worker's compensable personal injury, occupational disease or mental disorder. In making this decision, the Board may consider medical opinion or other expert professional advice.**

**Health care may continue even if the worker is not disabled from earning full wages at the work at which he or she is employed, or is retired from the workforce.**

### 2.3 When a Worker Leaves British Columbia

**Workers who reside in British Columbia on the date of injury and subsequently wish to leave the province, either temporarily or permanently, are required to discuss the potential health care ramifications with the Board. If leaving British Columbia might impede the worker's recovery, compensation may be suspended if the circumstances set out in Item C10-74.00, *Reduction or Suspension of Compensation*, are met.**

**The Board does not generally pay in excess of British Columbia rates for health care rendered outside the province to a worker who has voluntarily left the province.**

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**EFFECTIVE DATE:** July 18, 2018
**APPLICATION:** This Item applies on or after July 18, 2018.

WORK SAFE BC

**REHABILITATION SERVICES & CLAIMS MANUAL**

| RE: | Direction, Supervision, and Control of Health Care | ITEM: | C10-73.00 |
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# BACKGROUND

**1. Explanatory Notes**

**This policy sets out the Board's responsibility for the direction, supervision, and control of health care for injured workers.**

**2. The Act**

**Section 21:**

**(1) See Item C10-72.00.**

**(2) Where in a case of emergency, or for other justifiable cause, a physician or qualified practitioner other than the one provided by the board is called in to treat the injured worker, and if the Board finds there was a justifiable cause and that the charge for the services is reasonable, the cost of the services must be paid by the Board.**

**…**

**(6) Health care furnished or provided … must at all times be subject to the direction, supervision and control of the Board; and the board may contract with physicians, nurses or other persons authorized to treat human ailments, hospitals and other institutions for any health care required, and to agree on a scale of fees or remuneration for that health care; and all questions as to the necessity, character and sufficiency of health care to be furnished must be determined by the board. …**

**(7) Without limiting the power of the board under this section to supervise and provide for the furnishing of health care in every case where it considers the exercise of that power is expedient, the board must permit health care to be administered, so far as the selection of a physician or qualified practitioner is concerned, by the physician or qualified practitioner who may be selected or employed by the injured worker.**




**Section 57(1):**

> **The board may require a worker who applies for or is in receipt of compensation . . . to be medically examined at a place reasonably convenient for the worker. If the worker fails to attend for the examination or obstructs the medical examiner, the worker's right to compensation is suspended until the examination has taken place, and no compensation is payable during the period of suspension.**

# POLICY

## 1. GENERAL

**Health care furnished or provided to injured workers is at all times subject to the direction, supervision, and control of the Board.**

**The Board determines all questions as to the necessity, character, and sufficiency of health care to be furnished or provided to injured workers. When making this determination, the Board may seek medical opinions or other expert professional advice to assist in determining if a given health care benefit or service is reasonably necessary.**

**The control of health care by the Board is not intended to exclude injured workers' choices. The Board uses its control over health care to do such things as ensure that health care options are not overlooked, promote recovery, facilitate return to work, and exclude choices by injured workers, physicians, qualified practitioners and/or other recognized health care professionals that will delay recovery, involve unnecessary or ineffective treatment, or create an unwarranted risk of further injury, increased disablement, disease or death. If there are reasonable choices of treatment, or reasonable differences of opinion among the medical profession with regard to the preferable treatment, or choices to be made that depend on personal preferences, the matter should be regarded as one of patient choice.**

**The Board's exercise of control relates largely to the approval or denial of health care payments, but can also include such things as directing an injured worker to be examined by a specialist or to attend a particular health care facility.**

**Where the Board considers health care to be reasonably necessary, and more than one type is available, the Board determines whether the choices are equally effective in terms of expected outcomes and length of disability, and are of a similar cost.**

**If there is a substantial difference in costs of equally effective health care options, the Board normally authorizes the option that is expected to be the least costly. In such cases, if the physician, qualified practitioner, other recognized health care professional, and/or worker chooses the more costly option, the Board pays for costs up to the amount that would have been paid for the authorized health care option.**

**If there is no substantial difference in costs between equally effective health care options, the choice is left to the worker.**

**Generally, the Board does not pay for health care that is new, non-standard or not generally accepted by the Board, unless prior approval has been obtained.**

## 2. SELECTION OF A PHYSICIAN OR QUALIFIED PRACTITIONER

**Subject to the Board's overriding supervisory power, the worker may select his or her own physician or qualified practitioner. For the purpose of section 21 of the *Act*, there is no distinction between a physician and a qualified practitioner.**

**Where a worker wishes to make a change of physician or qualified practitioner, the following guidelines apply:**

**(a) Where a worker moves his or her residence, a new physician or qualified practitioner may be selected in the new community without prior permission from the Board.**

**(b) Where a worker receives emergency treatment from a physician who is not the family physician, the worker may transfer to the family physician without prior permission from the Board.**

**(c) Where a worker wishes to change physician or qualified practitioner because of a loss of rapport with him or her, or because of a preference for a type of treatment available from a different type of physician or qualified practitioner, the change will be permitted unless the Board concludes that it is likely to be harmful, or medically unsound by reason of the circumstances relating to that particular case.**

**(d) Where a worker makes multiple changes of physicians or qualified practitioners and it appears to the Board that the worker is looking to find the physician or qualified practitioner whom the worker thinks is likely to provide a more favourable report, the Board may deny the change, and may not pay for treatment from the new physician or qualified practitioner. In determining whether to approve and pay for treatment from the worker's change of physician or qualified**

practitioner, the Board considers whether a rational treatment program is being followed.

(e) Where a worker attends walk-in clinics instead of, or in addition to, having a family physician and therefore does not see the same physician, the Board does not deny a worker's change of physician on this basis alone.

If the Board concludes that a worker's choice of physician or qualified practitioner is harmful or unsound, the decision is communicated to all physicians and qualified practitioners concerned, as well as to the worker. In these circumstances, the Board may reduce or suspend compensation if the circumstances in Item C10-74.00, *Reduction or Suspension of Compensation*, are met.

Where a worker attends a physician or qualified practitioner whose right to render health care has been cancelled or suspended by the Board under the provisions referred to in policy item #95.30, *Failure to Report*, the Board will not pay for the treatment or services rendered.

## 3. CONCURRENT TREATMENT

Concurrent treatment occurs when a worker's treatment is overseen by more than one physician or qualified practitioner at a time.

The Board's general position is that a worker's treatment should be overseen by only one physician or qualified practitioner at a time.

There are cases, however, where the Board may consider concurrent treatment to be reasonable.

The Board may consider concurrent treatment reasonable in situations such as when a worker's disability requires treatment by a physician and a specialist, by two or more specialists, or by a qualified practitioner with concurrent monitoring by a physician. The Board may also consider concurrent treatment reasonable when a worker is transitioning from one form of treatment to another. In this instance, the Board may determine that it is warranted for the treatments to overlap for a limited time.

The Board does not refuse concurrent treatment simply because it is inconsistent with a rule or policy of a professional organization.

## 4. AUTHORIZATION OF ELECTIVE SURGERY

**Elective surgery is considered optional or not urgently necessary surgical treatment.**

**The Board does not expect physicians or qualified practitioners working under emergency conditions to obtain prior authorization from the Board before performing necessary surgical treatments. However, the Board does not generally pay for any elective surgical treatments unless prior authorization from the Board has been obtained.**

**The Board determines whether to authorize elective surgery based on the applicable medical evidence. The Board may refuse to authorize an elective surgical treatment if the Board considers it to be:**

- **unduly hazardous, having regard to its potential benefits and the risks involved in not having the surgery;**
- **unlikely to promote recovery;**
- **unnecessary; or**
- **reasonable to try less invasive measures first.**

**Before the Board refuses authorization of an elective surgical treatment, the Board normally discusses this decision with the worker's physician or qualified practitioner. The Board notifies the worker and the worker's physician or qualified practitioner of its decision.**

**If the worker decides to proceed with the unauthorized elective surgical treatment, the Board does not pay for the treatment or any expenses associated with recovery from that treatment. As well, the Board may consider the worker to have engaged in an insanitary or injurious practice, and may reduce or suspend the worker's compensation, if the circumstances in Item C10-74.00, *Reduction or Suspension of Compensation*, are met.**

## 5. EXAMINATIONS

**An injured worker's physician, qualified practitioner or other recognized health care professional may request that the Board conduct a medical examination of the injured worker. Similarly, the Board may direct an injured worker to submit to a medical examination.**

**A "medical examination" is not limited to examinations performed by physicians. It also includes examinations by qualified practitioners and other recognized**

**health care professionals. The term "examination" may include a consultation (e.g. with a dentist), or an assessment (e.g. by a psychologist).**

**A Board-directed medical examination may be conducted by the worker's own physician, the Board or an external physician, qualified practitioner or other recognized health care professional, as determined by the Board.**

**In all cases, the Board notifies the injured worker in advance of the type of physician, qualified practitioner or other recognized health care professional who will conduct the examination. The Board also notifies the injured worker's physician, qualified practitioner, or other recognized health care professional of its intention to proceed with a Board-directed medical examination.**

**Following a Board-directed medical examination, the Board notifies the worker's physician, qualified practitioner or other recognized health care professional of those medical matters that should be brought to their attention following the examination.**

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| **EFFECTIVE DATE:** | **July 18, 2018** |
| **APPLICATION:** | **This Item applies on or after July 18, 2018.** |

WORK SAFE BC

**REHABILITATION SERVICES & CLAIMS MANUAL**

| RE: Reduction or Suspension of Compensation | ITEM: C10-74.00 |
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# BACKGROUND

**1. Explanatory Notes**

**This policy outlines the circumstances in which the Board may suspend a worker's compensation for failing to attend or obstructing a medical examination, and reduce or suspend a worker's compensation for refusing to submit to medical or surgical treatment or persisting in insanitary or injurious practices.**

**2. The Act**

**Section 1:**

> **"compensation" includes health care;**
>
> **"health care", when used in Part 1, includes the things which the board under this Act is empowered to provide for injured workers;**

**Section 57:**

> **(1) The board may require a worker who applies for or is in receipt of compensation under this Part to be medically examined at a place reasonably convenient for the worker. If the worker fails to attend for the examination or obstructs the medical examiner, the worker's right to compensation is suspended until the examination has taken place, and no compensation is payable during the period of suspension.**
>
> **(2) The board may reduce or suspend compensation when the worker**
>
> > **(a) persists in insanitary or injurious practices which tend to imperil or retard his or her recovery; or**
> >
> > **(b) refuses to submit to medical or surgical treatment which the board considers, based on expert medical or surgical advice, is reasonably essential to promote his or her recovery.**


**REHABILITATION SERVICES & CLAIMS MANUAL**

# POLICY

## 1. GENERAL

**Where certain prerequisites are satisfied, the Board may reduce or suspend a worker's compensation. The situations where this may occur are discussed in more detail in the sections that follow.**

**The reduction or suspension of compensation commences as of the date of the Board's decision. This includes the reduction or suspension of health care on the claim, as the definition of "compensation" in the *Act* includes health care.**

**The reduction or suspension of compensation is limited to the claim at issue and does not apply to any compensation the worker may be receiving under other claims.**

### 1.1 Reasonable Explanation

**Prior to reducing or suspending compensation, the Board gives a worker an opportunity to provide an explanation for the worker's conduct. If the Board considers there is a reasonable explanation, compensation is not reduced or suspended. Reasonable explanations include, but are not limited to:**

- **unexpected illness;**
- **compelling personal reasons, such as a death in the family; or**
- **unexpected transportation difficulty where a reasonable attempt was made to overcome the difficulty, such as by using an alternate mode of transportation.**

**If the Board does not consider there to be a reasonable explanation for the worker's conduct, or if an explanation is not forthcoming, the Board may proceed to reduce or suspend compensation.**

### 1.2 Reinstatement of Compensation

**Generally, when compensation is reinstated following a period of reduction or suspension, it is reinstated prospectively from the date of the Board's decision to reinstate. If the Board's decision to reduce or suspend compensation includes the reduction or suspension of the worker's right to health care, the Board does not pay health care accounts that are incurred during the period of the reduction or suspension.**

**If the worker provides a reasonable explanation for the conduct that resulted in the reduction or suspension, the Board may reinstate the compensation retroactively to the date it was reduced or suspended. In this case, the Board may pay any outstanding health care accounts incurred during the period of the reduction or suspension.**

**If a worker's temporary disability stabilizes as a permanent impairment while compensation is reduced or suspended, the effective date of the resulting permanent disability award is the date on which the worker's temporary disability stabilized as a permanent impairment, not the day following the date of reduction or suspension of compensation.**

## 2. FAILURE TO ATTEND OR OBSTRUCTION OF A MEDICAL EXAMINATION

**Section 57(1) of the *Act* suspends a worker's right to compensation on a claim if the worker fails to attend or obstructs a medical examination. The worker's right to compensation on the claim is suspended until the examination that the worker failed to attend or obstructed has taken place and been effectively completed.**

**In applying this section of the *Act*, the Board does not limit the term "medical examination" to examinations performed by physicians. It also includes examinations by qualified practitioners and other recognized health care professionals. The term "examination" may include a consultation (e.g. with a dentist), or an assessment (e.g. by a psychologist).**

**In determining whether a worker has failed to attend a medical examination, the Board considers whether the worker:**

- **has received notice of the date, time and place of the appointment;**
- **did not attend; and**
- **did not give adequate notice that he or she would not be attending.**

**In determining whether a worker has obstructed a medical examination, the Board considers whether the worker behaved in a manner that prevented the examination from being effectively completed.**

**Before the Board suspends a worker's compensation for failing to attend or obstructing an examination, the Board takes the following actions:**

**(a) The Board determines whether the worker has failed to attend or has obstructed an examination.**

(b) If the Board determines the worker has failed to attend or has obstructed an examination, the Board then advises the worker that all compensation on the claim will be suspended if the examination is not effectively completed and attempts to reschedule the examination.

(c) If the worker fails to reschedule or continues to avoid or obstruct the examination, the Board gives the worker an opportunity to provide an explanation for the worker's conduct.

(d) If the Board does not consider the worker's explanation to be reasonable, the Board suspends the worker's compensation on the claim.

When the Board notifies the worker of its decision to suspend compensation under section 57(1) of the *Act*, the Board includes notice of a further appointment for the examination, and advises that, if the worker attends and allows the examination to be effectively completed, compensation will be reinstated.

## 3. PERSISTING IN INSANITARY OR INJURIOUS PRACTICES

The Board has discretion under section 57(2)(a) of the *Act* to determine whether and how a worker's compensation may be affected by the worker's persistence in insanitary or injurious practices that tend to imperil or retard the worker's recovery. The Board may reduce the worker's compensation, suspend the worker's compensation or continue with the worker's compensation.

If the Board chooses to reduce the worker's compensation, the Board has the further discretion to determine whether the reduction of the compensation means suspending the health care on that claim or just suspending the wage-loss or permanent disability award payment on that claim.

Before the Board reduces or suspends a worker's compensation for persisting in insanitary or injurious practices, the Board takes the following actions:

(a) The Board determines whether the worker is engaging in an insanitary or injurious practice that tends to imperil or retard the worker's recovery, taking medical opinion or other expert professional advice into consideration as necessary.

(b) If the Board determines the worker is engaging in an insanitary or injurious practice, the Board then advises the worker that the practice may inhibit recovery or lead to further injury and must be discontinued, otherwise some or all of the compensation on the claim may be reduced or suspended.

(c) If the worker persists in the insanitary or injurious practice, the Board gives the worker an opportunity to provide an explanation for the worker's conduct.

(d) If the Board does not consider the worker's explanation to be reasonable, the Board determines whether to reduce the worker's compensation on the claim (e.g. suspend wage-loss or permanent disability award payments, but not health care) or suspend all of the worker's compensation on the claim (including health care).

If the Board reduces or suspends the worker's compensation on the claim under section 57(2)(a) of the *Act*, the worker must satisfy the Board that the insanitary or injurious practice has ceased and will not be repeated, before the Board reinstates full compensation.

Compensation may be terminated on other grounds if the insanitary or injurious practice a worker is engaged in shows that the worker was not disabled during the period in question, or if the evidence indicates that the worker's disability is due to the insanitary or injurious practice rather than to the original compensable personal injury, occupational disease or mental disorder.

## 4. REFUSAL TO SUBMIT TO MEDICAL OR SURGICAL TREATMENT

The Board has discretion under section 57(2)(b) of the *Act* to reduce or suspend a worker's compensation where the worker refuses to submit to medical or surgical treatment that the Board considers, based on medical opinion or other expert professional advice, is reasonably essential to promote the worker's recovery.

If the Board chooses to reduce or suspend the worker's compensation, the Board has the further discretion to determine whether the reduction or suspension of the compensation applies to wage-loss and/or health care on that claim.

In applying this section of the *Act*, the Board does not limit the phrase "medical or surgical treatment" to treatment performed by physicians. It also includes treatment provided by qualified practitioners and other recognized health care professionals that the Board considers, based on medical opinion or other expert professional advice, reasonably essential to promote the worker's recovery.

Before the Board reduces or suspends a worker's compensation for refusing to submit to treatment, the Board takes the following actions:

(a) The Board determines whether the worker is refusing to submit to treatment.

**(b)** **If the Board determines the worker is refusing to submit to treatment, the Board obtains medical opinion or other expert professional advice that the treatment in question is reasonably essential to promote the worker's recovery.**

**(c)** **If the Board determines the worker is refusing to submit to treatment that, based on medical opinion or other expert professional advice, is reasonably essential to promote the worker's recovery, the Board then:**

- **advises the worker of this decision and that some or all of the compensation on the claim may be reduced or suspended if the worker does not submit to the treatment; and**
- **gives the worker an opportunity to provide an explanation for the worker's conduct.**

**(d)** **If the Board does not consider the worker's explanation to be reasonable, the Board determines whether to reduce the worker's compensation on the claim (e.g. suspend wage-loss or permanent disability award payments, but not health care) or suspend all of the worker's compensation on the claim (including health care).**

**If the Board reduces or suspends the worker's compensation on the claim under section 57(2)(b) of the *Act*, the worker must submit to the Board-approved medical or surgical treatment, before the Board reinstates compensation.**

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| **EFFECTIVE DATE:** | **July 18, 2018** |
| **APPLICATION:** | **This Item applies on or after July 18, 2018.** |

WORK SAFE BC

REHABILITATION SERVICES & CLAIMS MANUAL

| RE: Health Care Accounts – General | ITEM: C10-75.00 |
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# BACKGROUND

**1. Explanatory Notes**

**This policy provides guidance on the manner in which the Board administers health care accounts.**

**2. The Act**

**Section 21:**

> **(1) See Item C10-72.00.**
>
> **…**
>
> **(6) See Item C10-73.00.**

**Section 56(3):**

> **Unless the board otherwise directs, an account for medical services or health care must not be paid if it is submitted later than 90 days from the date that**
>
> **(a) the last treatment was given; or**
>
> **(b) the physician or person furnishing the medical service was first aware that the board may be liable for his or her services,**
>
> **whichever first occurs.**

# POLICY

**1. DEFINITIONS**

**As set out in Item C10-72.00, *Health Care – Introduction*, "health care account" means a statement of fees owed for goods and/or services supplied, which a physician, qualified practitioner or other recognized health care professional submits to the Board (including reporting or form fees) for health care provided to a worker.**

**"Reporting or form fees" means fees in relation to reports or forms that physicians, qualified practitioners or other recognized health care professionals submit to the Board.**

## 2. SUBMISSION OF HEALTH CARE ACCOUNTS

**The Board audits all health care accounts submitted to ensure compliance with the *Act*, any applicable contracts and fee schedules, and to ensure that the health care provided is appropriate given the worker's compensable disability.**

**The Board may be in receipt of health care accounts that the Board does not pay for a number of reasons. Such reasons include, but are not limited to the following:**

- **the health care provided to a worker is not related to the worker's compensable personal injury, occupational disease or mental disorder;**
- **the Board does not consider the health care provided to a worker to be reasonably necessary to treat the compensable personal injury, occupational disease or mental disorder;**
- **the Board has determined that the worker's compensable personal injury, occupational disease or mental disorder has resolved;**
- **the Board considers the report in support of the health care account inadequate; or**
- **a previous decision to allow the worker's claim for personal injury, occupational disease or mental disorder is reversed on reconsideration, review or appeal.**

**If the Board is in receipt of a health care account that the Board will not pay, the Board notifies the physician, qualified practitioner or other recognized health care professional who submitted the health care account as soon as possible.**

**As required by the *Act*, the physician, qualified practitioner or other recognized health care professional must submit health care accounts promptly after health care is provided. Where a health care account is not submitted promptly and the delay hinders the Board's decision-making ability, the Board may not pay the health care account.**

## 3. AMOUNTS PAYABLE

**The amounts the Board pays to physicians, qualified practitioners or other recognized health care professionals are generally governed by contracts and/or fee schedules, which the Board may specifically negotiate or may adopt from another agency. If there is no contract and/or fee schedule in place with respect**

to certain health care, the Board pays an amount for that health care that it considers reasonable.

Where the Board considers certain health care to be reasonably necessary, and more than one type is appropriate and available, but there is a substantial difference in costs, the Board normally only authorizes and pays for costs up to the amount that would have been paid for the less expensive but equally effective option.

Physicians, qualified practitioners and other recognized health care professionals are not permitted to bill a worker for any amount in excess of the amount payable by the Board. If they do so and the worker pays, the Board reimburses the worker for the excess amount and may recover that amount by deducting it from future health care accounts that the physician, qualified practitioner or other recognized health care professional submits to the Board. It is recommended, however, that workers contact the Board for information on the amount payable by the Board before obtaining non-emergency health care.

A physician, qualified practitioner or other recognized health care professional may choose to see a worker in a health care facility other than his or her own office. In such cases, the Board only pays for the services of the physician, qualified practitioner or other recognized health care professional and does not pay any additional fees for use of the health care facility. This would apply, for example, if a physician chooses to see a worker at a hospital rather than his or her office.

## 4. ADMINISTRATION OF HEALTH CARE ACCOUNTS

### 4.1 Before Initial Claims Adjudication

Generally, the Board only pays health care accounts after the worker's claim for personal injury, occupational disease or mental disorder is allowed. However, the Board may pay health care accounts submitted before a claim is initially adjudicated where the health care provided is:

- emergency health care necessary to optimize recovery (e.g. emergency surgery); or
- necessary to assist in the adjudicative process. This includes reporting or form fees, and fees for any Board-directed examination, consultation or assessment undertaken on an investigative basis.

Unless pre-authorized, the Board does not generally pay health care accounts in respect of investigative surgery because such invasive procedures could result in a disability. If a worker chooses to pay for and undergo investigative surgery, the Board may consider any resultant reports in adjudicating the worker's claim.

**If the claim is subsequently allowed, the Board may then pay the health care account for the investigative surgery.**

**If a worker's claim for personal injury, occupational disease or mental disorder is not allowed, the Board does not pay wage-loss benefits for the period prior to the date of the decision, even though the Board may have paid for certain health care expenses during that period.**

### 4.2 Allowed Claims

#### 4.2.1 General

**When a claim for personal injury, occupational disease or mental disorder is allowed on initial adjudication, reconsideration, review or appeal, the Board does not solicit health care accounts for health care provided before the date of the decision to allow the claim. However, if the Board receives such health care accounts, and the decision allowing the claim does not deal with the question of entitlement to the health care at issue, the Board administers the health care accounts as if the claim had been allowed as of the date of injury.**

**The Board may reimburse a worker where the worker has received and paid for health care in good faith and on the advice of a physician, qualified practitioner or other recognized health care professional, even though the health care might not ordinarily be approved for the worker's compensable personal injury, occupational disease or mental disorder.**

#### 4.2.2 Compensable Disability Resolved

**Generally, the Board does not pay health care accounts for health care rendered after the date of the Board's decision that the compensable disability has resolved, unless the health care accounts are submitted promptly and in good faith in respect of reporting or form fees, or Board-directed examinations, consultations or assessments.**

#### 4.2.3 Entitlement to Treatment Limited

**After a worker's claim is allowed, the Board may decide to limit a worker's entitlement to a particular type of treatment, even though the worker continues to suffer from a compensable disability. The Board may decide to limit treatment in a number of situations. Such situations include, but are not limited to, the following:**

- **preventing the provision of concurrent treatment; or**
- **denying the extension of a particular type of treatment.**

**Generally, the Board does not pay health care accounts for health care rendered after the date of the Board's decision to limit a worker's entitlement to a particular type of treatment, unless the health care accounts are submitted promptly and in good faith in respect of treatment provided on or before the decision date.**

### 4.3 Disallowed or Rejected Claims

**A decision to disallow or reject a worker's claim for personal injury, occupational disease or mental disorder may be made on initial adjudication, reconsideration, review or appeal. Generally, the Board does not pay health care accounts for health care rendered after the date such a decision is made, unless they are submitted promptly and in good faith in respect of reporting or form fees, or Board-directed examinations, consultations or assessments.**

**When a worker's previously allowed claim for personal injury, occupational disease or mental disorder is subsequently disallowed or rejected, the Board does not initiate any steps to recover amounts the Board has already paid for health care. However, if the Board were offered reimbursement by any other agency, the offer would be accepted.**

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| **EFFECTIVE DATE:** | **July 18, 2018** |
| **APPLICATION:** | **This Item applies on or after July 18, 2018.** |

WORK SAFE BC

**REHABILITATION SERVICES & CLAIMS MANUAL**

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| **RE:** | **Health Care Accounts – Health Care Provided Out-of-Province** | **ITEM: C10-75.10** |

# BACKGROUND

**1. Explanatory Notes**

**This policy provides guidance on the manner in which the Board administers health care accounts in respect of health care provided outside of British Columbia.**

**2. The Act**

**Section 8(1):**

> **Where the injury of a worker occurs while the worker is working elsewhere than in the Province which would entitle the worker or the worker's dependants to compensation under this Part if it occurred in the Province, the board must pay compensation under this Part if**
>
> **(a) a place of business of the employer is situate in the Province;**
>
> **(b) the residence and usual place of employment of the worker are in the Province;**
>
> **(c) the employment is such that the worker is required to work both in and out of the Province; and**
>
> **(d) the employment of the worker out of the Province has immediately followed the worker's employment by the same employer within the Province and has lasted less than 6 months,**
>
> **but not otherwise.**

**Section 8.1:**

> **(1) The board may enter into an agreement or make an arrangement with Canada, a province or the appropriate authority of Canada or a province to provide for**

**(a) compensation, rehabilitation and health care to workers in accordance with the standards established under this *Act* or corresponding legislation in other jurisdictions,**

**(b) administrative co-operation and assistance between jurisdictions in all matters under this *Act* and corresponding legislation in other jurisdictions, or**

**(c) avoidance of duplication of assessments on workers' earnings.**

**(2) An agreement or arrangement under subsection (1) may**

**(a) waive or modify a residence or exposure requirement for eligibility for compensation, rehabilitation or health care, or**

**(b) provide for payment to the appropriate authority of Canada or a province for compensation, rehabilitation costs, or health care costs paid by it.**

**Section 21:**

**(1) See Item C10-72.00.**

**…**

**(6) See Item C10-73.00.**

# POLICY

## 1. DEFINITION

**"Non-resident worker" is an individual who is a "worker" under the *Act*, who either resides outside British Columbia on the date of injury, or moves outside British Columbia after the date of injury.**

## 2. GENERAL

**The Board expects workers to obtain health care in British Columbia for their compensable personal injuries, occupational diseases or mental disorder. However, the Board may consider that it is reasonably necessary for a worker to obtain health care in another jurisdiction.**

## 2.1 Emergency Health Care

**For workers whose employment takes them to other provinces or territories within Canada, the Board pays emergency health care accounts received from within Canada at the rates governed by inter-provincial fee schedules, which the Board establishes under section 8.1 of the *Act*.**

**The Board generally pays any out-of-country emergency health care accounts received at the rate established in the other jurisdiction, unless that rate is higher than the British Columbia rate. In these situations, the Board may negotiate a specific rate for the health care with the other jurisdiction.**

**Since emergency health care cannot be scheduled in advance, prior authorization from the Board is not required.**

## 2.2 Non-Emergency Health Care

**The Board should be notified before a worker obtains out-of-province non-emergency health care in order to ensure that the Board will pay for the health care. The Board may consider out-of-province non-emergency health care appropriate where:**

- **it is not reasonably available or not offered in British Columbia;**
- **it is medically appropriate (e.g. the worker's health could be put at risk by traveling a longer distance or waiting to return to British Columbia);**
- **the Board has entered into a service agreement with an out-of-province agency, and there is evidence that there will be reduced claim costs due to lower travel expenses and/or an earlier return to work; or**
- **the worker is a non-resident worker.**

**If the out-of-province non-emergency health care is obtained without prior approval from the Board, the Board may not pay for it if the Board determines that the health care was not an accepted part of the claim.**

**The Board generally pays any out-of-province non-emergency health care accounts received at the rate established in the other jurisdiction, unless that rate is higher than the British Columbia rate. In these situations, the Board may negotiate a specific rate for the health care with the other jurisdiction.**

**If a worker injured near the provincial border bypasses adequate health care in British Columbia and, by personal choice, elects to receive health care outside**

**the province, the Board does not normally pay in excess of British Columbia rates for that health care.**

## 3. REPORTS, FORMS AND OTHER INFORMATION

**A worker who receives health care outside British Columbia is responsible for ensuring the Board receives all health care reports, forms, receipts and any other requested information with respect to the worker's claim from the out-of-province health care provider.**

**The Board may reduce or suspend payments to a worker if the worker fails to provide the Board with the information that the Board considers necessary to administer the worker's claim. The Board may also reduce or suspend compensation where the circumstances set out in Item C10-74.00, *Reduction or Suspension of Compensation*, are met.**

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| **EFFECTIVE DATE:** | **July 18, 2018** |
| **APPLICATION:** | **This Item applies on or after July 18, 2018.** |

WORK SAFE BC

**REHABILITATION SERVICES & CLAIMS MANUAL**

| RE: | Physicians and Qualified Practitioners | ITEM: | C10-76.00 |
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# BACKGROUND

**1. Explanatory Notes**

**This policy provides guidance regarding an injured worker's entitlement to the services of a physician or qualified practitioner.**

**2. The Act**

**Section 1:**

> **"specialist" means a physician residing and practising in the Province and listed by the Royal College of Physicians and Surgeons of Canada as having specialist qualifications;**

**Section 21:**

> **(1) See Item C10-72.00.**
>
> **(2) See Item C10-73.00.**
>
> **…**
>
> **(6) See Item C10-73.00.**
>
> **(7) See Item C10-73.00.**
>
> **(8) The board may assume the responsibility of replacement and repair of**
>
> **…**
>
> > **(b) eyeglasses, dentures and hearing aids broken as a result of an accident arising out of and in the course of employment …**

**Section 56:**

**(1) It is the duty of every physician or qualified practitioner attending or consulted on a case of injury to a worker, or alleged case of injury to a worker, in an industry within the scope of this Part**

**. . .**

**(d) to give all reasonable and necessary information, advice and assistance to the injured worker and the worker's dependants in making application for compensation, and in furnishing in connection with it the required certificates and proofs, without charge to the worker.**

**(2) Every physician or qualified practitioner who is authorized by this *Act* to treat an injured worker is subject to like duties and responsibilities, and any health care furnished by the physician or qualified practitioner is subject to the direction, supervision and control of the board.**

**…**

**(4) A physician, qualified practitioner or other person authorized to render health care under this Part must confine his or her treatment to injuries to the parts of the body he or she is authorized to treat under the statute under which he or she is permitted to practise, and the giving of any unauthorized treatment is an offence against this Part.**

**(5) A physician, qualified practitioner or other person who fails to submit prompt, adequate and accurate reports and accounts as required by this *Act* or the board commits an offence against this Part, and his or her right to be selected by a worker to render health care may be cancelled by the board, or he or she may be suspended for a period to be determined by the board. When the right of a person to render health care is so cancelled or suspended, the board must notify the person of the cancellation or suspension, and must likewise inform the governing body named in the *Act* under which the person is authorized to treat human ailments, and the person whose right to render health care is cancelled or suspended must also notify injured workers who seek treatment from the person of the cancellation or suspension.**

**3. Health Professions Act**

**Section 12(1):**

> **The Lieutenant Governor in Council may, by regulation, designate a health profession for the purposes of this Act.**

**Section 15(1):**

> **On designation of a health profession under section 12 (1), a college responsible for carrying out the objects of this Act in respect of the health profession is established.**

# POLICY

## 1. ENTITLEMENT TO HEALTH CARE SERVICES

**An injured worker is entitled to the services of a physician and/or qualified practitioner as defined under the *Act*.**

**The Board establishes the types of treatment and fees it pays for health care and related services through contracts, or by implementation of fee schedules, as appropriate. If there is no contract or fee schedule in place at the time of service delivery with respect to a certain type of health care, the Board pays an amount for that health care that it considers reasonable.**

**Unless prior approval has been obtained, the Board does not generally pay for health care that is new or that it does not generally accept as reasonably necessary for the treatment of a compensable personal injury, occupational disease or mental disorder. The Board considers the scientific evidence and information regarding the effectiveness of such health care, as part of determining whether to grant approval.**

**Generally, the Board only pays health care accounts for treatment provided to injured workers at their residence, when the injured worker is non-ambulatory and the visit is pre-approved by the Board.**

## 2. GENERAL POSITION OF PHYSICIANS AND QUALIFIED PRACTITIONERS

**The Board's general position is that a worker's treatment should be overseen by only one physician or qualified practitioner at a time. There are cases, however, where the Board may consider concurrent treatment to be reasonable, as discussed in Item C10-73.00, *Direction, Supervision, and Control of Health Care*.**

**Physicians and qualified practitioners are confined to treat injuries to the parts of the body they are authorized by their governing statutes, regulations and bylaws to treat.**

**The Board may further limit the injuries and parts of the body they are authorized to treat. The provision of any unauthorized treatment is an offence. The maximum fine for committing this offence is set out in Appendix 6 to this *Manual*.**

**The Board will not pay for a worker to attend a physician or qualified practitioner whose right to render health care has been cancelled or suspended either by the licensing body, or by the Board under the provisions referred to in policy item #95.30, *Failure to Report*.**

**Physicians and qualified practitioners are required to submit prompt, adequate and accurate reports to the Board. These reports should include information on the diagnosis, the treatment possibilities, whether the injury, occupational disease or mental disorder could have been caused by the worker's employment, the worker's prognosis, and, where appropriate, expectations for return to work. Physicians and qualified practitioners are also required to give all reasonable and necessary information, advice and assistance to workers and their dependants in making an application for compensation.**

## 3. CONSULTATION WITH SPECIALIST PHYSICIANS

**On an accepted claim where health care is continuing, it is not necessary for a worker to obtain approval from the Board before seeing a specialist for a consultation, provided the necessity for consultation is shown on the referring physician's reports.**

**Where the Board arranges a referral with a specialist, the Board notifies the worker's physician or qualified practitioner.**

**When either the Board or the worker's physician refers a worker to a specialist and the specialist produces a report, the specialist is required to provide a copy of the report to both the Board and the worker's physician or qualified practitioner.**

### 3.1 Surgical Treatment

**Surgeons are one type of physician recognised by the Royal College of Physicians and Surgeons of Canada as having specialist qualifications.**

**The Board does not expect specialist physicians working under emergency conditions to obtain prior authorization from the Board before performing necessary surgical treatments.**

**However, prior authorization from the Board is required before a worker receives any elective surgical treatments, including investigative surgery, and the Board applies the policy in Item C10-73.00, *Direction, Supervision, and Control of Health Care*, in making this determination. If prior authorization is not obtained and the Board determines that the elective surgical treatment was not acceptable under the claim, the Board does not pay for the treatment.**

**The Board does not generally authorize investigative surgery before a claim is adjudicated, because such invasive procedures could result in a disability. However, if a worker pays the cost of investigative surgery, the Board may consider any resultant reports in adjudicating the worker's claim. If the claim is subsequently allowed, the Board may then pay the health care account for the investigative surgery under Item C10-75.00, *Health Care Accounts – General*.**

### 3.2 Psychiatric Consultation and Treatment

**A psychiatrist is one type of specialist physician. "Psychiatrist" means a physician who is recognized by the College of Physicians and Surgeons of British Columbia, or another accrediting body recognized by the Board, as being a specialist in psychiatry.**

**The Board generally approves psychiatric examination of a worker for the purposes of assessment or consultation on an investigative basis.**

**Prior to paying for psychiatric treatment, the Board requires an examination report from the worker's psychiatrist relating to diagnosis, etiology, treatment possibilities and prognosis.**

## 4. CHIROPRACTORS

**Registered members in good standing with the College of Chiropractors of British Columbia may provide chiropractic treatment and services to injured workers. Chiropractors may provide the chiropractic treatment and services authorized by the *Health Professions Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.**

### 4.1 Duration of Treatment

**The Board determines the duration of chiropractic treatment and services that it considers reasonable. The Board considers up to five weeks of chiropractic treatment reasonable for most compensable personal injuries, but pays for up to eight weeks of treatment.**

**The Board may pay for extensions beyond eight weeks based on a review of the evidence. The Board does not pay for more than one chiropractic treatment per day.**

### 4.2 Scope of Treatment

**The Board may set out the types of chiropractic treatment and services that it considers reasonable for most compensable personal injuries. The Board limits chiropractic treatment to the compensable area of injury and requires the chiropractic treatment to be reasonably necessary for the worker's compensable personal injury.**

**Prior to refusing or terminating authorization for chiropractic treatment, the Board considers all relevant medical opinions or other expert professional advice and information regarding the appropriateness of the treatment.**

**If the Board limits a worker's health care by terminating its authorization for chiropractic treatment, the Board communicates the decision to the chiropractor and the worker. The Board normally pays accounts for health care provided before the decision date.**

### 4.3 X-rays

**X-rays of the affected anatomical area may be taken for the purpose of assisting a chiropractor in the treatment of a worker. The Board pays health care accounts for x-rays in accordance with the current Board contract and/or fee schedule in place at the time of service delivery. The Board does not pay for:**

- **full-length views of the spine;**
- **x-rays of non-interpretable quality;**
- **x-rays of areas of the body not injured; and**
- **excess, or duplication of, x-rays.**

## 5. DENTISTS

**Registered members in good standing with the College of Dental Surgeons of British Columbia may provide dental treatment and services to injured workers. Dentists may provide the dental treatment and services authorized by the *Health Professions Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.**

**The Board generally pays for dental repair for damage caused by a compensable personal injury or occupational disease. "Personal injury" includes damage to dental crowns and fixed bridgework, as they are regarded as part of the anatomy. The Board pays for repair of dentures as set out in section 21(8)(b) of the *Act*.**

**Except in emergency cases, the Board does not pay health care accounts for dental treatments without prior Board approval of the dentist's proposed treatment.**

**Where there are two equally effective treatment plans, the Board normally authorizes the plan that is expected to be the least costly in the long term. If the dentist and/or a worker chooses the more costly option, the Board pays for costs up to the amount that would have been paid for the authorized dental treatment plan.**

## 6. PODIATRISTS

**Registered members in good standing with the British Columbia Association of Podiatrists may provide podiatric treatment and services to injured workers. Podiatrists may provide the podiatric treatment and services authorized by the *Health Professions Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.**

**The Board determines the podiatric services that it considers reasonable. The Board may pay for podiatric services such as: primary care services, referral services, and special podiatric procedures.**

## 7. NATUROPATHIC PHYSICIANS

**Registered members in good standing with the College of Naturopathic Physicians of British Columbia may provide naturopathic treatment and services to injured workers. Naturopathic physicians may provide the naturopathic treatment and services authorized by the *Health Professions Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.**

### 7.1 Duration of Treatment

**The Board determines the duration of naturopathic treatment and services that it considers reasonable. The Board considers up to eight weeks of naturopathic treatment reasonable for most compensable personal injuries, occupational diseases or mental disorder. The Board may pay for extensions of treatment beyond eight weeks based on a review of the evidence.**

## 7.2 Scope of Coverage

**The Board does not pay health care accounts for naturopathic remedies, treatments, or dietary supplements without prior Board approval of the naturopathic physician's proposed remedy, treatment, or supplement.**

**Following approval, the Board may pay health care accounts submitted by a naturopathic physician, medical laboratory, or a radiologist, for tests and services performed by or on behalf of the naturopathic physician, as they relate to the worker's compensable personal injury, occupational disease or mental disorder.**

## 8. NURSE PRACTITIONERS

**Nurse practitioners in good standing with the College of Registered Nurses of British Columbia may provide nursing treatment and services to injured workers. Nurse practitioners may provide the nursing treatment and services authorized by the *Health Professions Act* and corresponding regulation and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.**

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| **EFFECTIVE DATE:** | **July 18, 2018** |
| **APPLICATION:** | **This Item applies to health care expenses incurred and health care provided on or after July 18, 2018.** |

WORK SAFE BC

**REHABILITATION SERVICES & CLAIMS MANUAL**

| RE: Other Recognized Health Care Professionals | ITEM: C10-77.00 |
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# BACKGROUND

**1. Explanatory Notes**

**This policy provides guidance regarding an injured worker's entitlement to the services of recognized health care professionals, other than physicians and qualified practitioners.**

**2. The Act**

**Section 21:**

**(1) See Item C10-72.00.**

**…**

**(6) See Item C10-73.00.**

**…**

**(8) See Item C10-76.00.**

**Section 56:**

**…**

**(4) See Item C10-76.00.**

**3. Health Professions Act**

**Section 12(1):**

> **The Lieutenant Governor in Council may, by regulation, designate a health profession for the purposes of this Act.**

**Section 15(1):**

> **On designation of a health profession under section 12 (1), a college responsible for carrying out the objects of this Act in respect of the health profession is established.**


**REHABILITATION SERVICES & CLAIMS MANUAL**

# POLICY

## 1. DEFINITION

**As set out in Item C10-72.00, *Health Care – Introduction,* "other recognized health care professionals" are health care professionals other than physicians and qualified practitioners, recognized by the Board through contracts and/or fee schedules, to provide health care to injured workers, such as acupuncturists, audiologists, community health workers, denturists, dietitians, massage therapists, nurses other than nurse practitioners, occupational therapists, opticians, optometrists, pharmacists, physiotherapists, prosthetists and orthotists, psychologists, and other mental health care providers.**

## 2. AUTHORIZATION FOR HEALTH CARE SERVICES

**The Board may authorize persons other than physicians or qualified practitioners to provide health care to injured workers.**

**The Board establishes the types of treatment and fees it pays for health care through contracts or by implementation of fee schedules, as appropriate. If there is no contract and/or fee schedule in place with respect to a certain type of health care, the Board pays an amount that it considers reasonable.**

**Generally, the Board pays in accordance with the rates set out in the current Board contracts and/or fee schedules in place at the time of service delivery, regardless of whether the other recognized health care professional is a Board-authorized service provider under the contract and/or fee schedule.**

**Generally, the Board does not pay for health care that is new, non-standard or not generally accepted by the Board, unless prior Board approval has been obtained. The Board considers the scientific evidence and information regarding the effectiveness of such health care, when deciding whether to grant payment approval.**

**The Board only pays for the use of spas, public swimming pools or other exercise facilities as health care where the spa, public swimming pool or other exercise facility is used in the presence of another recognized health care professional as part of a Board-approved treatment program.**

**Generally, the Board only pays health care accounts for treatment provided to injured workers at their residence, when the injured worker is non-ambulatory and the visit is pre-approved by the Board.**

## 3. GENERAL POSITION OF OTHER RECOGNIZED HEALTH CARE PROFESSIONALS

**The Board's general position is that a worker should only be treated by one other recognized health care professional at a time.**

**Other recognized health care professionals are confined to treat injuries to the parts of the body they are authorized by their governing statutes, regulations and bylaws to treat. The Board may further limit the injuries and parts of the body they are authorized to treat. The provision of any unauthorized treatment is an offence. The maximum fine for committing this offence is set out in Appendix 6 to this *Manual*.**

**The Board does not pay for a worker to attend other recognized health care professionals whose rights to render health care have been cancelled or suspended either by the licensing body, or by the Board under the provisions referred to in policy item #95.30, *Failure to Report*.**

**Other recognized health care professionals are required to submit prompt, adequate and accurate reports to the Board. These reports should include information on the diagnosis, treatment possibilities, worker's prognosis, and, where appropriate, expectations for return to work.**

## 4. ACUPUNCTURISTS

**Registered members in good standing with the College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia may provide acupuncture treatment and services to injured workers. Acupuncturists may provide the acupuncture treatment and services authorized by the *Health Professions Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.**

**The Board may not pay for acupuncture treatment until it has received and approved a request from the acupuncturist outlining details such as the number of treatments expected, the treatment plan and the expected outcome.**

**The Board's approval of acupuncture treatment includes direction on the number of authorized treatment visits. In most cases, the Board limits payment to a maximum of five treatment visits over a two-week period from the date of the injured worker's first visit, unless otherwise stated in any current Board contract and/or fee schedule in place at the time of service delivery.**

## 5. AUDIOLOGISTS

**Registered members in good standing with the College of Speech and Hearing Health Professionals of British Columbia may provide audiology services to**

**injured workers. Audiologists may provide the audiology services authorized by the *Health Professions Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.**

**The Board determines whether it will pay for audiology services as part of an injured worker's claim. The Board pays health care accounts for audiology services according to any current Board contract and/or fee schedule in place at the time of service delivery.**

## 6. COMMUNITY HEALTH WORKERS

**Community health workers include residential care aides, personal care attendants, registered care attendants, home support workers, rehabilitation aides, or nurses' aides. Community health workers work under the direction and supervision of a physician, nurse practitioner, registered nurse or licensed practical nurse.**

**Where appropriate, the Board may pay health care accounts for community health workers to provide injured workers with treatments such as home wound care services or home intravenous therapy services. The Board administers these services pursuant to any current Board contract and/or fee schedule in place at the time of service delivery.**

## 7. DENTURISTS

**Registered members in good standing with the College of Denturists of British Columbia may provide denturist services to injured workers. Denturists may provide the denturist services authorized by the *Health Professions Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.**

**The Board pays reporting or form fees to denturists for any reports that the Board requires, and pays health care accounts according to any current Board contract and/or fee schedule in place at the time of service delivery.**

**The Board may not pay for denturist services until it has received and approved an estimate from the denturist outlining:**

- **the extent of dental damage;**
- **the method of restoration recommended; and**
- **the expected costs of the repair, itemized according to the current Board contract and/or fee schedule in place at the time of service delivery.**

## 8. DIETITIANS

Registered members in good standing with the College of Dietitians of British Columbia may provide dietetic services to injured workers. Dietitians may provide the dietetic services authorized by the *Health Professions Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

The Board determines whether it will pay for dietetic services as part of an injured worker's claim. The Board pays health care accounts for dietetic services according to any current Board contract and/or fee schedule in place at the time of service delivery.

## 9. MASSAGE THERAPISTS

Registered members in good standing with the College of Massage Therapists of British Columbia may provide massage therapy treatment and services to injured workers. Massage therapists, registered massage therapists, massage practitioners, and registered massage practitioners may provide the massage therapy treatment and services authorized by the *Health Professions Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

In most cases, the Board limits payment to a maximum of three treatment visits per week up to five weeks from the date of the injured worker's first visit, unless otherwise stated in any current Board contract and/or fee schedule in place at the time of service delivery. The Board may pay for extensions of massage therapy treatments beyond five weeks based on a review of the evidence.

The Board does not pay for more than one massage therapy treatment per day.

## 10. NURSES

Registered nurses in good standing with the College of Registered Nurses of British Columbia, and licensed practical nurses in good standing with the College of Licensed Practical Nurses of British Columbia, may provide nursing treatment and services to injured workers. Nurses may provide the nursing treatment and services authorized by the *Health Professions Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.

For workers who need nursing services while in a hospital, the necessary nursing service is determined and provided by the hospital. If the worker or the worker's family desires to have an additional or one-on-one nurse in attendance, the worker pays the cost of such nursing services.

**Where appropriate, the Board may pay health care accounts for nurses to provide injured workers with treatments such as home wound care services or home intravenous therapy services. The Board administers these services pursuant to any current Board contract and/or fee schedule in place at the time of service delivery. The Board accepts reports received from nurses in remote locations as medical reports if there is no physician in the immediate area.**

## 11. OCCUPATIONAL THERAPISTS

**Registered members in good standing with the College of Occupational Therapists of British Columbia may provide occupational therapy treatment and services to injured workers. Occupational therapists may provide the occupational therapy treatment and services authorized by the *Health Professions Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.**

**The Board determines whether it will pay for occupational therapy treatment and services as part of an injured worker's claim. The Board pays health care accounts for occupational therapy treatment and services according to any current Board contract and/or fee schedule in place at the time of service delivery.**

## 12. OPTICIANS

**Registered members in good standing with the College of Opticians of British Columbia may provide opticianry services to injured workers. Opticians, dispensing opticians and contact lens fitters may provide the opticianry services authorized by the *Health Professions Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.**

**The Board determines whether it will pay for opticianry services as part of an injured worker's claim. The Board pays health care accounts for opticianry services according to any current Board contract and/or fee schedule in place at the time of service delivery.**

## 13. OPTOMETRISTS

**Registered members in good standing with the College of Optometrists of British Columbia may provide optometry treatment and services to injured workers. Optometrists may provide the optometry treatment and services authorized by the *Health Professions Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.**

**The Board determines whether it will pay for optometry treatment and services as part of an injured worker's claim. The Board pays health care accounts for optometry treatment and services according to any current Board contract and/or fee schedule in place at the time of service delivery.**

## 14. PHARMACISTS

**Registered members in good standing with the College of Pharmacists of British Columbia may provide pharmacy services to injured workers. Pharmacists may provide the pharmacy services authorized by the *Health Professions Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.**

**The Board determines whether it will pay for pharmacy services as part of an injured worker's claim. The Board pays health care accounts for pharmacy services according to any current Board contract and/or fee schedule in place at the time of service delivery.**

## 15. PHYSIOTHERAPISTS

**Registered members in good standing with the College of Physical Therapists of British Columbia may provide physical therapy treatment and services to injured workers. Physical therapists, registered physical therapists, physiotherapists, registered physiotherapists, remedial gymnasts and registered remedial gymnasts may provide the physical therapy treatment and services authorized by the *Health Professions Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.**

**In most cases, the Board limits payment to a maximum of one visit per day up to eight weeks, or 22 visits, whichever is earlier, from the date of the injured worker's first visit, unless otherwise stated in any current Board contract and/or fee schedule in place at the time of service delivery. The Board may pay for extensions of physical therapy treatments and services beyond eight weeks or 22 visits based on a review of the evidence.**

## 16. PROSTHETISTS AND ORTHOTISTS

**Registered members in good standing with the Canadian Board for Certification of Prosthetists and Orthotists may provide prosthetic or orthotic services and devices to injured workers. Prosthetists and orthotists may provide prosthetic or orthotic services and devices as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.**

**The Board determines whether it will pay for prosthetic or orthotic services and devices as part of an injured worker's claim. The Board pays health care**

**accounts for prosthetic or orthotic services and devices according to any current Board contract and/or fee schedule in place at the time of service delivery.**

## 17. PSYCHOLOGISTS AND COUNSELLORS

**Registered members in good standing with the College of Psychologists of British Columbia may provide psychological treatment and services to injured workers. Psychologists, registered psychologists, psychological associates and registered psychological associates may provide psychological treatment and services as authorized by the *Health Professions Act* and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.**

**Registered clinical counsellors in good standing with the British Columbia Association of Clinical Counsellors, or Canadian certified counsellors in good standing with the Canadian Counselling and Psychotherapy Association, may provide counselling treatment and services to injured workers. Registered clinical counsellors and Canadian certified counsellors may provide counselling treatment and services as authorized by their governing bodies and corresponding regulations and bylaws, and as outlined in any current Board contract and/or fee schedule in place at the time of service delivery.**

**The Board determines whether it will pay for psychological or counselling treatment and services as part of an injured worker's claim. The Board pays health care accounts for psychological or counselling treatment and services according to any current Board contract and/or fee schedule in place at the time of service delivery.**

**When psychological or counselling treatment and/or services are required, the Board arranges for a psychologist or counsellor to provide treatment and/or services to the worker according to the Board's Agreement for Mental Health Providers for Psychology Assessment Services, the Mental Health Treatment Service Agreement, and accompanying guidelines.**

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| **EFFECTIVE DATE:** | **July 18, 2018** |
| **APPLICATION:** | **This Item applies to health care expenses incurred and health care provided on or after July 18, 2018.** |

WORK SAFE BC

**REHABILITATION SERVICES & CLAIMS MANUAL**

| RE: Health Care Facilities | ITEM: C10-78.00 |
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# BACKGROUND

**1. Explanatory Notes**

**This policy provides guidance on the payment of health care accounts for services provided at health care facilities.**

**2. The Act**

**Section 21:**

**(1) See Item C10-72.00.**

**(2) See Item C10-73.00.**

**…**

**(6) See Item C10-73.00.**

# POLICY

**1. GENERAL**

**As set out in Item C10-72.00, *Health Care – Introduction*, "health care facility" means a hospital; surgical facility; office of a physician, qualified practitioner or other recognized health care professional; group home; or other place where acute, intermediate or long-term health care services or programs, are provided.**

**The Board pays for health care provided at health care facilities that the Board considers reasonably necessary in the diagnosis and treatment of an injured worker. This includes, but is not limited to, emergency services, laboratory tests and diagnostic imaging services.**

**Prior Board approval is normally required for diagnostic imaging services, such as MRIs, PET Scans and CT scans. Where prior Board approval is not obtained, the Board may still pay the health care account in emergency situations or where the Board determines that the procedure was reasonably necessary.**

**The Board pays for medically necessary supplies, assistive devices or appliances, approved by the Board, that are provided by the health care facility to the worker for his or her use following discharge from the facility. Examples of such items include, but are not limited to, crutches, braces and casts.**

**The amounts payable to health care facilities for health care provided to injured workers are generally governed by contracts and/or fee schedules negotiated by the Board.**

## 2. OVERNIGHT STAY

**Where in-patient per diem rates are paid to health care facilities, such rates are inclusive of all essential costs associated with an overnight stay including additional nursing services, special beds, medications, or any other additional services or equipment.**

**The Board pays for accommodation in a standard ward. The Board may pay for private or semi-private accommodation where it is cost effective in minimizing wage-loss resulting from a delayed admission to the health care facility, or if the Board considers such accommodation to be reasonably necessary due to the nature of the compensable personal injury, occupational disease or mental disorder.**

**The Board may pay for the cost of telephone and television rentals where the worker is required to remain in a health care facility for longer than one night.**

## 3. HEALTH CARE FACILITIES OTHER THAN ACUTE CARE HOSPITALS

**Health care facilities other than acute care hospitals may be used for the pre-operative or post-operative treatment of injured workers who require active nursing services, or for operative purposes, if a worker requires expedited surgery. The Board only pays for health care at this type of facility where Board approval has been obtained before the worker is admitted.**

**Where prior Board approval is not obtained, the Board may pay for the health care provided where the Board determines that the health care was reasonably necessary. The Board establishes rates for payment, taking into consideration such things as:**

- **the purpose and necessity of the health care;**
- **the level of care required; and/or**
- **the regulatory authority of the health care facility.**

## 4. REDUCTION OR SUSPENSION OF COMPENSATION

**The Board's approval must be obtained for any absence from a health care facility for any purpose other than medical treatment and examination. The Board does not pay for an overnight stay in a health care facility during such a period of absence unless prior Board approval for the absence has been obtained.**


## REHABILITATION SERVICES & CLAIMS MANUAL

**Cases of a worker's misconduct, while admitted to a health care facility, may result in the Board reducing or suspending the worker's compensation if the circumstances in Item C10-74.00, *Reduction or Suspension of Compensation* are met.**

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| **EFFECTIVE DATE:** | **July 18, 2018** |
| **APPLICATION:** | **This Item applies to health care expenses incurred and health care provided on or after July 18, 2018.** |

WORK SAFE BC

**REHABILITATION SERVICES & CLAIMS MANUAL**

| RE: | Health Care Supplies and Equipment | ITEM: | C10-79.00 |
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# BACKGROUND

**1. Explanatory Notes**

**This policy provides guidance on an injured worker's entitlement to, and the repair and replacement of, health care supplies and equipment.**

**2. The Act**

**Section 16:**

**(1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the board may take the measures and make the expenditures from the accident fund that it considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.**

**(2) Where compensation is payable under this Part as the result of the death of a worker, the board may make provisions and expenditures for the training or retraining of a surviving dependent spouse, regardless of the date of death.**

**(3) The board may, where it considers it advisable, provide counselling and placement services to dependants.**

**Section 21:**

**(1) See Item C10-72.00.**

**...**

**(9) Where an injury to a worker results in serious impairment of the worker's sight, the board may, to protect the worker's remaining vision, provide the worker with protective eyeglasses.**

# POLICY

**1. GENERAL**

**The Board may pay for health care supplies and equipment that it considers reasonably necessary to cure and relieve and/or alleviate the effects of the worker's personal injury, occupational disease or mental disorder, and to assist**

in recovery. The Board considers medical opinion or other expert professional advice and cost effectiveness in making this determination.

Health care supplies and equipment may be provided on a temporary or a permanent basis.

Optional upgrades on health care supplies and equipment that are not medically necessary to relieve the worker from the effects of the compensable disability are at the worker's own expense.

### 1.1 Repair and Replacement of Health Care Supplies and Equipment

The Board may pay for the repair and/or maintenance of health care supplies and equipment. In paying for repair and/or maintenance, the Board may establish an allowance in lieu of requiring ongoing submission of receipts. The amount of the allowance is based on the Board's experience as to the normal wear and tear, maintenance requirements and life span of the item in question.

The Board may pay for replacement of health care supplies and equipment when there is a demonstrated deficiency or deterioration in the item, there is a change in the worker's condition such that the item no longer meets the worker's needs, the item cannot be cost effectively repaired, and/or the item jeopardizes the worker's safety. Replacement of health care supplies and equipment is based on the Board's experience as to the normal wear and tear and life span of the item in question.

The Board may not pay for the repair or replacement of health care supplies and equipment if the loss or damage is a result of deliberate misuse, abuse, or occurs with excessive frequency.

## 2. TYPES OF HEALTH CARE SUPPLIES AND EQUIPMENT

Set out below are some of the health care supplies and equipment paid for by the Board and the conditions and criteria for their coverage. The list is not exhaustive. A worker or the worker's physician, qualified practitioner or other recognized health care professional may contact the Board to determine if the Board will pay for a particular item.

### 2.1 Medical Supplies

The Board may pay for medical supplies required to treat a worker's compensable personal injury, occupational disease or mental disorder where recommended by the worker's physician, qualified practitioner or other recognized health care professional. The Board may require medical or other expert professional reports to support the necessity of specific medical supplies.

### *2.1.1 Prescription Medications*

**The Board may pay for prescription medication where the Board determines that it is reasonably necessary to treat the worker's compensable disability. The Board generally pays for medications at the equivalent generic drug rate.**

**Payment for opioids, sedative/hypnotic, and other potentially addictive drugs are discussed in Item C10-80.00, *Potentially Addictive Drugs*.**

### *2.1.2 Prescription Eyeglasses*

**The Board may pay for prescription eyeglasses for workers whose eyesight is affected as a result of a compensable personal injury or occupational disease. The Board may pay for tinted lenses if required for the compensable disability and if prescribed by a physician or qualified practitioner.**

**The Board may pay for contact lenses if the Board considers they would be more appropriate for the compensable personal injury or occupational disease and more beneficial to the worker than prescription eyeglasses.**

**If a worker loses the sight or a substantial part of the sight of one eye due to a compensable personal injury or occupational disease, the Board may pay for protective glasses with hardened lenses to protect the remaining vision. The Board may also pay for an ocular prosthesis (artificial eye) if it considers the ocular prosthesis to be reasonably necessary.**

**In all cases, the Board establishes the rates of payment for prescription eyeglasses, contact lenses and protective eyewear.**

### *2.1.3 Hearing Aids*

**A worker with a work-related loss of hearing may be eligible to receive a hearing aid, depending on the level of hearing loss. The Board determines the level of hearing loss, with advice from a certified audiologist. The Board establishes rates for the provision of hearing aids by contracting with Board-authorized service providers.**

**If a hearing aid is not obtained from a Board-authorized service provider, any additional costs incurred by the worker, beyond the Board-established rates for the provision of hearing aids, are at the worker's own expense.**

**Special accessories for the hearing aid (e.g. a telephone amplifier) may be paid for in cases where it is considered reasonably necessary by the Board.**

**The Board may pay for a bilateral hearing aid where required due to a worker's level of hearing loss.**

## 2.2 Artificial Appliances

**The Board pays for the most medically and functionally appropriate and cost effective artificial appliances. In making this determination, the Board may consider, among other factors, whether:**

- **the appliance is required due to a compensable personal injury or occupational disease;**
- **the appliance is prescribed by the worker's physician or qualified practitioner; and/or**
- **the provision of the artificial appliance is supported by objective medical evidence or other expert professional advice.**

### *2.2.1 Prosthetic Appliances*

**The Board only pays for prosthetic appliances if they are requisitioned from facilities that have registered prosthetists or similarly qualified professionals on their staff.**

**The Board may pay for cosmetic restoration for aesthetic rather than functional purposes in order to alleviate the impact of the compensable disability and promote social and psychological well-being. Examples of cosmetic restoration include, but are not limited to, skin matching, artificial fingers or partial hands, artificial noses, and artificial ears.**

**The Board may establish guidelines with respect to the provision of advanced technologies, such as myoelectric and computerized prostheses.**

### *2.2.2 Orthotic Appliances*

**The Board may pay for orthotic appliances on one or more occasions to assist with recovery, improve or maintain functional abilities, and to assist with return to work.**

**Examples of orthotic appliances include, but are not limited to, spinal or leg braces, back braces, or splints.**

## 2.3 Footwear

**The Board may pay for customized or commercial footwear when the Board determines that the provision of footwear is warranted due to the compensable disability. The Board may also pay where customized or commercial footwear is a requirement for treatment or rehabilitation or where the worker's existing footwear is not sufficient or cannot be adequately modified.**

**In making this determination, the Board considers whether the provision of footwear will enable the worker to return to work and to meet any workplace safety requirements. The Board generally pays for footwear for a worker with a temporary disability on a one-time only basis.**

**In all cases, when the worker's disability warrants the provision of footwear, either customized or commercial, the Board pays for the most medically appropriate and cost effective alternative.**

### 2.4 Mobility-Related Devices

**The Board may pay for mobility-related devices to assist permanently disabled workers with activities of daily living and/or instrumental activities of daily living that the worker is unable to carry out due to the compensable personal injury or occupational disease. The Board makes its determination on the provision of mobility-related devices based on medical opinion, other expert professional advice, and the cost effectiveness of the device. Examples of mobility-related devices include, but are not limited to, canes, crutches, walkers, manual wheelchairs, scooters and power wheelchairs.**

**The Board may rent a mobility-related device for a worker whose temporary disability severely restricts his or her mobility and the device is medically necessary to address the worker's mobility needs.**

**The Board pays for wheelchairs for workers who are permanently disabled and whose ability to walk is so severely restricted that the use of any other mobility device, including a mobility scooter, is insufficient to address the worker's mobility needs. The Board determines the type of wheelchair to purchase, either manual or power, based on medical opinion or other expert professional advice establishing necessity and cost effectiveness. The Board may rent a wheelchair for a worker whose temporary disability severely restricts his or her mobility, and the use of any other mobility-related device is insufficient to address the worker's mobility needs.**

### 2.5 Recreational Prosthetic Appliances and Mobility Devices

**The Board may pay for recreational prosthetic appliances, mobility devices, or specialized sports devices for exercise purposes in certain circumstances. In determining whether a recreational prosthetic appliance, mobility device, or specialized sports device is appropriate, the Board considers the following:**

- **the physical and psychological benefits to the worker;**
- **the worker's demonstrated ability to maintain an active lifestyle;**
- **the physical ability of the worker to use the equipment independently and safely;**

- the potential risk of additional injuries to the worker;
- the assessment of the equipment and its reliability;
- the cost effectiveness; and
- any previous recreational prosthetic appliances, mobility devices, or specialized sports devices supplied to the worker.

The Board normally pays for recreational prosthetic appliances, mobility devices, or specialized sports devices for one recreational activity at a time. The Board may pay for another recreational prosthetic appliance, mobility device, or specialized sports device when the Board determines that the previously provided device is no longer appropriate.

### 2.6 Miscellaneous Items

The Board may pay for miscellaneous health care supplies and equipment that it considers reasonably necessary for the health care needs of an injured worker, or that are designed to assist with the activities of daily living.

Examples of such items include, but are not limited to:

- raised toilet seats and commodes;
- wheelchair and pressure relief cushions;
- hand held shower heads, grab bars, bath benches, non-slip bath mats, and safety poles;
- long-handled shoe horns and elastic shoelaces; and
- supplies to assist with personal hygiene such as tubing, urinary drainage bags, catheters, suppositories, disposable gloves, and other bladder and bowel routine care supplies.

For workers who require an adjustable bed due to the compensable personal injury or occupational disease, the Board may also pay for items such as:

- adjustable hospital-type beds and adjustable bed mattresses; and/or
- pressure relieving mattresses or overlays where needed to prevent skin breakdown or spasm.

Generally, the Board does not pay for general household items such as hot tubs, televisions, linens and furniture.


# REHABILITATION SERVICES & CLAIMS MANUAL

**EFFECTIVE DATE:** July 18, 2018

**APPLICATION:** This Item applies to health care expenses incurred and health care provided on or after July 18, 2018.

WORK SAFE BC

REHABILITATION SERVICES & CLAIMS MANUAL

| RE: Potentially Addictive Drugs | ITEM: C10-80.00 |
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# BACKGROUND

**1. Explanatory Notes**

**This policy provides guidance regarding the authorization of payment for potentially addictive drugs.**

**2. The Act**

**Section 21:**

**(1) See Item C10-72.00.**

**...**

**(6) See Item C10-73.00.**

# POLICY

**1. GENERAL**

**The Board may pay for potentially addictive drugs prescribed to an injured worker following the worker's injury or most recent surgery, for the treatment of conditions arising from the worker's compensable personal injury, occupational disease or mental disorder.**

**The Board generally only pays for prescribed potentially addictive drugs that are administered orally, except in immediate post-injury, operative, peri-operative or palliative situations.**

**The following sections set out when the Board pays for the prescription of opioids, sedative/hypnotics or other potentially addictive drugs. A list of specific potentially addictive drugs covered by this policy may be obtained by contacting the Board.**

**2. AUTHORIZATION FOR PRESCRIBED OPIOIDS**

**The Board may pay for prescribed opioids for up to four weeks. The Board does not consider payment beyond four weeks appropriate in most cases.**

**In exceptional cases, the Board may pay for extensions of opioid prescriptions beyond four weeks if, among other considerations:**

- **there is objective medical opinion or other expert professional advice that treatment with opioids is resulting in improvement of pain and function, enabling the worker to return to work, perform activities of daily living, and/or perform instrumental activities of daily living; and**
- **the use of opioids is part of an integrated approach to overall pain management.**

**The Board does not pay for extensions of opioid prescriptions until it has received and approved a request from the physician or qualified practitioner outlining details such as the treatment plan, dosage, frequency, and progress expectations.**

**The Board also requires the worker to complete a written treatment agreement outlining the conditions of the extension being granted.**

**As part of the Board's integrated approach to overall pain management, the Board reviews long-term treatment plans involving the use of opioids on a periodic basis. The Board also refers to best practice treatment guidelines and other expert scientific and medical evidence on the treatment and management of opioids and other potentially addictive drugs.**

### 3. AUTHORIZATION FOR PRESCRIBED SEDATIVE/HYPNOTICS

**The Board may pay for prescribed sedative/hypnotics for up to two weeks. The Board does not consider payment beyond two weeks appropriate in most cases.**

**In exceptional cases, the Board may pay for extensions of sedative/hypnotic prescriptions beyond two weeks if, among other considerations:**

- **the Board has accepted a psychological condition under the claim and the worker is under the care of a psychiatrist;**
- **the sedative/hypnotic medication is prescribed to treat spasticity associated with a compensable condition such as a spinal cord injury, or**
- **the extension is for a short duration (one to two days) and is associated with an upcoming scheduled medical investigation or procedure.**

## 4. AUTHORIZATION FOR OTHER PRESCRIBED POTENTIALLY ADDICTIVE DRUGS

**The Board does not pay for any other potentially addictive drugs prescribed to an injured worker, unless their use is part of an integrated approach to overall pain management and the Board has received:**

- **a request from the physician or qualified practitioner outlining details such as the treatment plan, dosage, frequency, and progress expectations; and**
- **a written treatment agreement, which outlines the conditions of payment, signed by the worker.**

## 5. CANCELLATION OF PAYMENT FOR ALL PRESCRIBED POTENTIALLY ADDICTIVE DRUGS

**The Board may restrict or discontinue the authorization of payment for prescribed potentially addictive drugs if, among other considerations, the Board determines that:**

- **the worker's pain and/or function has improved completely or significantly, and treatment with the potentially addictive drug is no longer medically necessary;**
- **there is no improvement in the worker's pain and/or function;**
- **the prescribed potentially addictive drug results in adverse side effects;**
- **the worker is in contravention of one or more of the conditions set out in his or her written treatment agreement; or**
- **there is a reasonable risk of misuse.**

## 6. EXCEPTIONS

**In cases where a worker is receiving palliative care, the Board may determine the duration of a worker's entitlement to prescribed potentially addictive drugs based on the physician or qualified practitioner's treatment plan and the individual merits of the case.**

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| **EFFECTIVE DATE:** | **July 18, 2018** |
| **APPLICATION:** | **This Item applies to health care expenses incurred and health care provided on or after July 18, 2018.** |

WORK SAFE BC

**REHABILITATION SERVICES & CLAIMS MANUAL**

| RE: Home and Vehicle Modifications | ITEM: C10-81.00 |
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# BACKGROUND

**1. Explanatory Notes**

**This policy sets out an injured worker's entitlement to home and/or vehicle modifications.**

**2. The Act**

**Section 21:**

**(1) See Item C10-72.00.**

**...**

**(6) See Item C10-73.00.**

# POLICY

**1. GENERAL**

**The Board may pay for home and/or vehicle modifications where they are required due to a compensable personal injury or occupational disease. The Board retains ownership of the modifications and may reclaim them when they are no longer required.**

**2. HOME MODIFICATIONS**

**The Board may pay for home modifications that are reasonably necessary to improve a worker's access to areas of his or her home and to assist with activities of daily living. In making this determination, the Board considers:**

- **the nature and severity of the worker's disability;**
- **the expected duration of the worker's disability (i.e., whether it will be temporary or permanent);**
- **the medical necessity of the modifications requested;**
- **the scope of the modifications requested;**

- **the suitability of the worker's home for modification:**
  - **whether the home is structurally sound;**
  - **whether the modifications are a viable option; and**
  - **whether the worker owns or rents the home;**
- **the cost effectiveness of the proposed modifications; and**
- **whether any alternative modifications may be more appropriate to address the impact of the worker's disability or functional needs.**

**Prior approval by the Board is required for payment of any home modifications. Any unauthorized modifications or upgrades may be at the worker's own expense.**

**If necessary, the Board may relocate the worker to a suitable temporary accommodation during the home modification process.**

**Minor home modifications may include, but are not limited to: the installation of grab-bars, ceiling poles, hand rails, handheld showers, or wing taps for sinks.**

**The Board may pay for minor home modifications for workers who own or rent the home they live in. Where applicable, the Board requires written authorization from a landlord, strata corporation, cooperative, or similar entity, prior to any modifications to the home.**

**The Board may pay for minor home modifications on more than one occasion based on the Board's assessment of the worker's continued need for the home modifications, with reference to the factors listed above.**

**The Board may pay for major home modifications for severely disabled workers as set out in Item C10-84.00, *Additional Benefits for Severely Disabled Workers*.**

### 3. VEHICLE MODIFICATIONS

**The Board may pay for vehicle modifications that are reasonably necessary to improve a worker's mobility and independence outside of the home, and to address the transportation and access needs of the worker. In making this determination, the Board considers:**

- **the nature and severity of the worker's disability;**

- **the expected duration of the worker's disability (i.e., whether it will be temporary or permanent);**
- **the medical necessity of the modifications requested;**
- **the scope of the modifications requested;**
- **the suitability of the worker's vehicle for modification:**
  - **whether the transmission is automatic or manual; and/or**
  - **whether the vehicle is large enough for the modifications required;**
- **the cost effectiveness of the proposed modifications;**
- **if the worker is driving the vehicle, whether he or she is eligible to drive;**
- **if the worker is not driving the vehicle, the intended driver of the vehicle; and**
- **whether any alternative modifications may be more appropriate to address the impact of the worker's disability or functional needs.**

**Prior approval by the Board is required for payment of any vehicle modifications. Any unauthorized modifications or upgrades may be at the worker's own expense. Only the worker's primary vehicle is modified.**

**Minor vehicle modifications may include, but are not limited to: hand controls, parking brake extension levers, power parking brakes, left hand gear selection levers, spinner knobs for steering wheels, gas guards, chest harnesses/seatbelts, or pedal extensions.**

**The Board may pay for minor vehicle modifications for workers who own or lease their vehicle. If the worker leases a vehicle, written authorization from the lessor is also necessary prior to any modification to the leased vehicle.**

**The Board may pay for minor vehicle modifications on more than one occasion based on the Board's assessment of the worker's continued need for the vehicle modification, with reference to the factors listed above.**

**The Board may pay for major vehicle modifications for severely disabled workers as set out in Item C10-84.00, *Additional Benefits for Severely Disabled Workers*.**

## 4. MAINTENANCE AND REPAIRS OF HOME AND VEHICLE MODIFICATIONS

**The Board does not pay the cost of general maintenance and repairs of homes and/or vehicles that would be required regardless of the compensable personal injury or occupational disease, even if some equipment has been supplied by the Board.**

**The Board may pay for the maintenance and/or repair of home and/or vehicle modifications that are specifically required due to the worker's compensable personal injury or occupational disease.**

**The worker is responsible for any repair and/or maintenance costs of home and vehicle modifications resulting from deliberate misuse or abuse by the worker.**

**If a worker's home and/or vehicle insurance premiums increase due to a home or vehicle modification, the Board may pay for the amount of the increase.**

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| **EFFECTIVE DATE:** | **July 18, 2018** |
| **APPLICATION:** | **This Item applies to health care expenses incurred and health care provided on or after July 18, 2018.** |

WORK SAFE BC

**REHABILITATION SERVICES & CLAIMS MANUAL**

| RE: Clothing Allowances | ITEM: C10-82.00 |
|---|---|

# BACKGROUND

**1. Explanatory Notes**

**This policy provides guidance on a worker's entitlement to clothing allowances.**

**2. The Act**

**Section 21:**

**(1) See Item C10-72.00.**

# POLICY

**1. GENERAL**

**The Board may pay the clothing allowances set out below to upper and/or lower limb amputees wearing prostheses, and to workers wearing an upper or lower limb brace, or a back brace. The amputation must be at or above the wrist, or at or above the ankle. An upper limb brace is a brace worn at or above the wrist. The brace must be either a major joint brace with rigid frame or contain rigid materials; or a hard back brace, with a rigid frame or shell. Workers are paid a clothing allowance under one category as set out below:**

| | Jan. 1, 2017 – Dec. 31, 2017 | Jan. 1, 2018 – Dec. 31, 2018 |
|---|---|---|
| Upper Limb | $344.03 | $348.83 |
| Lower Limb | $689.75 | $699.37 |
| Bilateral Limb | $689.75 | $699.37 |
| Upper and Lower Limb | $1,033.90 | $1,048.32 |

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

**The Board also pays the allowance to a worker confined to a wheelchair, who is not otherwise entitled, at the upper and lower limb rate. The Board pays the allowance to a worker wearing a back brace at the upper and lower limb rate.**

**Effective January 1st, 2008, the Board adjusts the amounts of the clothing allowances on January 1st of each year. The Board determines the percentage change to be applied annually to these amounts by comparing the percentage change in the consumer price index for October of the previous year with the consumer price index for October of the year prior to the previous year.**

**The Board automatically pays the clothing allowance to a worker with an amputation at or above the wrist, or at or above the ankle. Proof is not required of the wearing of the prosthesis or prostheses, nor of the replacement, repair, or damage to clothing. In the case of braces however, the Board only pays the clothing allowance contingent on the worker's continued wearing of the apparatus as prescribed. Similarly, in the case of a worker confined to a wheelchair, the Board only pays the clothing allowance contingent on the worker's continued use of the wheelchair as prescribed.**

**Entitlement to the clothing allowance commences as of the date of the amputation or the worker commencing to use the brace or wheelchair. The Board makes the first payment following the initiation of the permanent disability award and this first payment includes any retroactive entitlement for prior periods of disability not previously paid. Subsequent payments are made annually.**

**The Board withholds payment of the clothing allowance while a worker is in prison. The Board pays the amount withheld to the worker on release, if the period in prison was less than one year. If the period in prison was more than one year, the Board does not pay the clothing allowance for each full year the worker was in prison.**

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| **EFFECTIVE DATE:** | **July 18, 2018** |
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WORK SAFE BC

**REHABILITATION SERVICES & CLAIMS MANUAL**

| RE: Transportation | ITEM: C10-83.00 |
|---|---|

# BACKGROUND

**1. Explanatory Notes**

**This policy provides guidance on when the Board pays transportation costs as health care.**

**2. The Act**

**Section 21:**

**(1) See Item C10-72.00.**

**…**

**(3) … Every employer must, at the employer's own expense, furnish to a worker injured in the employer's employment, when necessary, immediate conveyance and transportation to a hospital, physician or qualified practitioner for initial treatment.**

**…**

**(7) See Item C10-73.00.**

# POLICY

**1. DEFINITIONS**

**As set out in Item C10-72.00, *Health Care – Introduction*, "residence" means the place where a worker lives or regularly stays. Where the worker has more than one residence, the worker is required to identify one as the primary residence.**

**As set out in Item C10-73.00, *Direction, Supervision, and Control of Health Care*, a "medical examination" is not limited to examinations performed by physicians. It also includes examinations by qualified practitioners and other recognized health care professionals. The term "examination" may include a consultation (e.g., with a dentist), or an assessment (e.g., by a psychologist).**

## 2. ELIGIBILITY

**The Board may pay for transportation for a worker to receive Board-approved health care for a compensable personal injury, occupational disease or mental disorder.**

**Transportation costs may be paid where the distance between the point of origin and the destination is 20 kilometres or greater, one way, for:**

**(a) travel to a health care facility to obtain Board-approved health care;**

**(b) visits to the worker's residence while the worker is participating in a Board-approved health care program lasting six weeks or more, during which the worker is required to stay in other accommodation. The Board may pay for transportation in respect of such visits once every three weeks, if the worker's recovery would not be impeded;**

**(c) return travel to the worker's residence if, at the time of the compensable personal injury, occupational disease or mental disorder, the worker is working at a location other than his or her resident community, and the worker's disability from the compensable personal injury, occupational disease or mental disorder prevents the worker from returning to his or her place of residence using his or her usual mode of transportation; or**

**(d) travel in connection with attendance at a Board or Workers' Compensation Appeal Tribunal directed medical examination or inquiry.**

**Transportation costs are not normally paid for:**

**(a) The first 20 kilometres of any journey, except where the Board determines that the worker's condition is such as to require travel by:**

**ambulance or other method of emergency transportation (not including the date of injury transportation as per section 21(3)); or taxi.**

**(b) travel related to attendance at a return to work program; or**

**(c) the portion of any journey which takes place beyond the boundary of the province. This does not apply where the Board specifically requests the worker to attend a medical examination, or in certain situations specified in policy item #100.15, *Worker Resides Outside the Province*, in relation to claims or Review Division inquiries.**

**To determine the amount payable for transportation, the Board considers the most reasonably direct route available from the point of origin to the destination. The point of origin is usually the worker's residence.**

**Where a worker is required to travel to attend a vocational rehabilitation appointment, other than as part of a vocational rehabilitation plan, the Board pays for transportation in the same manner and at the same rates as set out in this policy. Where a worker is participating in a vocational rehabilitation plan, the Board may establish the amount paid for transportation separately as part of that plan.**

### 2.1 Worker Bypasses Nearby Health Care Facilities

**Workers may choose to bypass adequate health care facilities and travel a further distance to attend a particular physician, qualified practitioner or other recognized health care professional of their own choice. Subject to the Board's authority to direct, supervise and control treatment, workers may select their own physician, qualified practitioner or other recognized health care professional.**

**However, the Board may place limits on the transportation it pays for when a worker bypasses adequate nearby health care facilities and incurs additional transportation costs to attend another health care facility because of personal preference. In cases where the Board determines that travelling a further distance to a health care facility is not reasonably necessary, the Board only pays for transportation in respect of travel to the nearest health care facility that the Board considers adequate.**

**If a worker moves his or her residence to another location while receiving compensation, the Board will use the worker's new residence as the point of origin for determining the worker's eligibility. In these situations, the Board does not normally pay:**

- **(a) the cost of the move from one place of residence to another as health care; or**
- **(b) increased transportation costs for a worker to bypass an adequate health care facility to attend a physician, qualified practitioner or other recognized health care professional in his or her former resident community simply on the basis of the worker's personal preference.**

**If a worker receiving health care benefits moves out of British Columbia, the Board pays for transportation in accordance with the amounts payable as set out in section 5 of this policy and on the same basis as if the worker continued to reside in British Columbia.**

## 3. MODE OF TRANSPORTATION

**When evaluating the most appropriate mode of transportation, the Board may consider:**

- **the nature and extent of the worker's compensable personal injury, occupational disease or mental disorder;**
- **any pre-existing medical and/or psychological conditions;**
- **the urgency of the health care;**
- **any potential safety issues with various modes of transportation;**
- **availability of particular travel modes;**
- **travel times and distance;**
- **worker's travel preference and convenience;**
- **expected weather and road conditions during travel; and**
- **cost of the mode of transportation.**

**Following these considerations, the Board recommends a suitable mode of transportation that is safe, expedient, practical and cost effective.**

**Where the Board considers that the worker's choice of transportation would put the worker's safety at risk, the Board may consider the worker to be engaging in an insanitary or injurious practice, and therefore reduce or suspend the worker's compensation, if the circumstances in Item C10-74.00, *Reduction or Suspension of Compensation*, are met.**

## 4. MANNER OF PAYMENT

**Whenever possible, the Board schedules and pays for transportation directly. A worker may be required to reimburse the Board for the amounts paid directly where:**

**(a) the worker either does not attend, or does not attend in part, the health care in respect of which the transportation was paid or does not use the pre-arranged mode of transportation; and**

**(b) the amounts paid directly cannot be refunded or transferred to be used at another time.**

**In these cases, the worker may also be required to reimburse the Board for additional costs, and any change or cancellation fees associated with the transportation where the Board determines:**

**(a) there is no reasonable explanation that would justify the worker's actions, such as unexpected illness or compelling personal reasons (e.g. a death in the family); or**

**(b) the change or cancellation was due to the worker's personal choice or preference, not related to the worker's compensable or non-compensable disability.**

**If it is not possible for the Board to schedule transportation directly or where mileage is paid, the Board may pay a transportation allowance to the worker in advance of the travel for the expected transportation costs incurred, up to an amount the Board considers reasonable. A worker is required to reimburse the Board for the transportation allowance where:**

**(a) the worker either does not attend, or does not attend in part, the health care in respect of which the transportation allowance was paid; and**

**(b) the allowance cannot be applied towards the transportation at another time.**

**The Board may recover the amounts paid:**

- **for transportation booked directly,**
- **through the provision of a transportation allowance, and/or**
- **for change fees, cancellation fees, or additional costs.**

**The Board may recover the above amounts by treating them as an overpayment and deducting them from the worker's compensation, or the worker may reimburse the Board directly.**

**If direct booking or payment by way of a travel allowance is not possible, the worker generally pays transportation costs as they are incurred, and advises the Board of the amount paid. The Board then calculates the amount of transportation payable and reimburses the worker for that amount.**

## 5. AMOUNT PAYABLE

**If the worker chooses to take a mode of transportation other than the one recommended by the Board, the Board pays for the more cost effective option, which is usually bus fare, together with transportation to and from the bus**

terminal. In this regard, the Board may establish a schedule of rates, adjusted periodically. Otherwise, the following sections set out how the Board determines how much it will pay for transportation for a worker's receipt of health care.

### 5.1 Travel by Air

Where the Board considers travel by air to be the most appropriate mode of transportation for the worker, the Board pays for transportation equal to the cost of the airfare, together with the cost of transportation to and from airports.

### 5.2 Travel by Public Transportation

Where the Board considers travel by public transportation to be the most appropriate mode of local transportation for the worker, the Board pays for transportation equal to the actual cost of the public transportation.

Generally, the Board considers travel by public transportation the most appropriate mode of local transportation where it is available and is a reasonable means of travel for the journey to be made by the worker.

### 5.3 Travel by Private Vehicle

Where the Board considers travel by private vehicle to be the most appropriate mode of transportation for the worker, the Board pays for transportation based on mileage at the rate set out below:

| Date | Amount Per Kilometre |
|---|---|
| January 1, 2017 – December 31, 2017 | 42¢ |
| January 1, 2018 – December 31, 2018 | 43¢ |

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

Effective June 30, 2002, the Board adjusts the mileage rate annually on January 1st of each year using the percentage change in the consumer price index, rounded to the nearest cent.

### 5.4 Travel by Taxi

Where the Board considers travel by taxi to be the most appropriate mode of transportation for the worker, the Board pays a transportation amount equal to the actual cost of taxi fares. The Board may consider travel by taxi reasonably

**necessary where, given the nature and extent of the worker's compensable or pre-existing personal injury, occupational disease or mental disorder:**

**(a) no other mode of transportation is appropriate for local travel; or**

**(b) when travelling to a distant centre for health care, the worker:**

**(i) requires transportation from his or her residence to or from an airport or commercial bus or ferry terminal; or**

**(ii) requires transportation while at the distant centre, for example, between health care facilities or between a health care facility and his or her place of accommodation.**

### 5.5 Parking and Toll Fees

**Regardless of whether the Board pays for mileage, the Board pays reasonable parking charges and toll fees the worker incurs while attending a health care facility, or in connection with travel to or from a health care facility (including, for example, parking charges at an airport, ferry terminal or bus terminal). The Board does not pay for parking violations.**

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| **EFFECTIVE DATE:** | **July 18, 2018** |
| **APPLICATION:** | **This Item applies to health care expenses incurred and health care provided on or after July 18, 2018.** |

WORK SAFE BC

**REHABILITATION SERVICES & CLAIMS MANUAL**

| RE: Subsistence Allowances | ITEM: C10-83.10 |
|---|---|

# BACKGROUND

**1. Explanatory Notes**

**This policy provides guidance on when the Board pays subsistence allowances as a health care benefit.**

**2. The Act**

**Section 1:**

> **"dependant" means a member of the family of a worker who was wholly or partly dependent on the worker's earnings at the time of the worker's death, or who but for the incapacity due to the accident would have been so dependent…**

**Section 5(2):**

> **See Item C10-72.00.**

**Section 21(1):**

> **See Item C10-72.00.**

**Section 34:**

> **In fixing the amount of a periodic payment of compensation, consideration must be had to payments, allowances or benefits which the worker may receive from the worker's employer during the period of the disability, including a pension, gratuity or other allowance provided wholly at the expense of the employer, and a sum deducted under this section from the compensation otherwise payable may be paid to the employer out of the accident fund.**

# POLICY

**1. DEFINITIONS**

**"Subsistence" generally refers to the means for supporting the basic necessities of life; such as, accommodation, meals, income loss and dependant care.**

**As set out in Item C10-72.00, *Health Care – Introduction*, "residence" means the place where a worker lives or regularly stays. Where a worker has more than one residence, the worker is required to identify one as the primary residence.**

## 2. OVERVIEW

**The following sections provide guidance on when the Board pays a subsistence allowance for accommodation, meals, income loss and/or dependant care required as a result of a worker's attendance at a Board-approved health care appointment or program.**

**Where a worker is required to attend a vocational rehabilitation appointment, other than as part of a vocational rehabilitation plan, the Board pays subsistence allowances in the same manner and at the same rates as set out in this policy. Where a worker is participating in a vocational rehabilitation plan, the Board may establish the amount paid for subsistence separately as part of that plan.**

## 3. ACCOMMODATION

### 3.1 Eligibility

**Where a worker is required to spend one or more nights away from his or her residence to obtain Board-approved health care for a compensable personal injury, occupational disease or mental disorder, the Board may pay a subsistence allowance to cover the cost of accommodation.**

**In determining whether a worker is required to stay away from his or her residence for one or more nights, the Board considers a number of factors, including:**

- **the travel times and distance associated with roundtrip travel, as impacted by carrier schedules (e.g. flight, bus, ferry);**
- **the anticipated duration of the health care appointment or the health care program;**
- **the timing of the health care appointment or the health care program (e.g. early or late in the day, or over multiple days);**
- **the worker's transportation and accommodation preferences;**
- **the impact of travel on the worker's compensable disability;**
- **any potential safety issues with the travel and accommodation;**
- **any pre-existing medical and/or psychological conditions;**

- **the expected weather and road conditions during the proposed period of travel; and**

- **the cost effectiveness of roundtrip travel as compared to the cost of subsistence associated with an overnight stay.**

### 3.2 Amounts Payable

**Whenever possible, the Board schedules and pays for accommodation directly. If it is not possible for the Board to schedule accommodation directly, the Board pays the worker a subsistence allowance for the actual accommodation costs incurred, up to an amount that the Board considers reasonable.**

**The Board may recommend a particular accommodation based on:**

- **the nature of the worker's medical condition;**

- **the medical opinion or other expert professional advice it receives;**

- **any contracts the Board has entered into with accommodation providers; and**

- **the proximity of the recommended accommodation to the health care appointment.**

**If the worker wishes to stay elsewhere, the Board pays a subsistence allowance equal to the most cost effective option. Where the worker wishes to stay with a friend or family member, the Board does not pay a subsistence allowance for accommodation. In all cases where a worker chooses to stay somewhere other than the recommended option, any additional transportation costs are paid for by the worker.**

**Where the Board considers that the worker's choice or location of accommodation would put the worker's safety at risk, the Board may consider the worker to be engaging in an insanitary or injurious practice, and therefore reduce or suspend the worker's compensation, if the circumstances in Item C10-74.00, *Reduction or Suspension of Compensation*, are met.**

**Where accommodation is included in the amount the Board pays for a health care program, the Board does not pay any additional subsistence allowance for accommodation.**

## 4. MEALS

### 4.1 Eligibility

**The Board may pay a subsistence allowance to cover the cost of meals where, in connection with attendance at a Board-approved health care appointment or program, the worker:**

- **travels by air; or**
- **is required to be away from his or her residence for 10 hours or more.**

**In these cases, the Board may pay a subsistence allowance to cover the cost of those meals missed due to the worker being away from his or her residence over the entire meal period(s).**

**For the purposes of this policy, meal periods are defined as follows:**

| Meal | Time Period |
|---|---|
| Breakfast | 6:30 to 8 am |
| Lunch | 12 to 1 pm |
| Dinner | 5 to 6:30 pm |

**If a worker is eligible for payment for transportation to visit his or her residence while participating in a Board-approved health care program, the worker may also be eligible for a subsistence allowance for meals during the course of travel to and from the worker's residence.**

**The Board only pays the subsistence allowance for meals during the course of travel if the worker chooses the Board's recommended mode of transportation. For example, if the Board recommends air travel, but the worker chooses to drive, the Board pays the subsistence allowance for meals based on the meal periods that would have been missed had the worker travelled by air.**

## 4.2 Amounts Payable

**Where the eligibility requirements are met, the Board pays a subsistence allowance for meals with reference to the full or partial per diem meal allowance rates set out below:**

| Date | Breakfast | Lunch | Dinner | Per Day |
|---|---|---|---|---|
| January 1, 2017 – December 31, 2017 | $12.99 | $16.03 | $27.58 | $56.60 |
| January 1, 2018 – December 31, 2018 | $13.17 | $16.25 | $27.96 | $57.38 |

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

**Effective June 30, 2002, the Board adjusts the meal allowance rates annually on January 1st of each year using the percentage change in the consumer price index.**

**Where meals are included in the amount the Board pays to a health care facility, the Board does not pay any additional subsistence allowances for meals.**

# 5. INCOME LOSS

## 5.1 Eligibility

**Where a worker who is not disabled from working loses time from work to attend Board-approved health care, and thereby incurs a loss of income, the Board may pay a subsistence allowance to compensate the worker for that income loss. These situations involve either:**

- **a worker who has never been declared disabled as the result of a compensable personal injury, occupational disease or mental disorder; or**
- **a worker who has returned to work following a period of compensable disability, but is still undergoing Board-approved health care.**

**When evaluating whether to pay a subsistence allowance for income loss and how much to pay, the Board takes into account whether the income loss is due to the worker's personal choice of health care provider. If it involves bypassing a closer health care provider whom the Board considers adequate, the Board may not pay any, or as much, subsistence allowance for income loss.**

**The Board pays a subsistence allowance for income loss where the Board determines it is unreasonable for the worker to attend health care outside of work**

**hours. Generally, the Board does not pay a subsistence allowance for income loss if the time loss incurred is under two hours; however, the Board may pay a subsistence allowance for income loss if the worker's aggregate time loss resulting from multiple appointments results in a significant income loss.**

**While these payments are not wage-loss compensation, the Board applies the provisions of section 5(2) of the *Act*. As such, the Board does not pay a subsistence allowance for income loss for losses incurred on the day of the injury.**

**In situations where the worker is maintained on full salary by the employer and an entitlement to a subsistence allowance for income loss has arisen, the Board may pay the subsistence allowance for income loss to the employer under the terms of section 34 of the *Act*.**

### 5.2 Amounts Payable

**A subsistence allowance for income loss is equal to 75% of the worker's actual current loss. However, it is subject to the same maximum and minimum rules that are applicable to temporary total disability benefits. (See #34.20 and #69.00.)**

## 6. TEMPORARY DEPENDANT CARE DURING PERIOD OF DISABILITY

### 6.1 Eligibility

**The Board may cover the cost of temporary dependant care during a period of disability where the Board determines that:**

- **(a) the costs are incurred by a worker as a result of the worker's compensable personal injury, occupational disease or mental disorder;**
- **(b) the costs are over and above dependant care costs the worker normally incurred prior to the compensable personal injury, occupational disease or mental disorder; and**
- **(c) no other suitable arrangements can be made with family, friends, or through the use of community resources.**

**The types of situations where the Board may pay a subsistence allowance on a temporary basis to cover dependant care costs include, but are not limited to, situations where:**

- **(a) the worker requires emergency treatment and must be immediately transported to a health care facility, thereby leaving dependants unattended;**

**(b) the worker is required to attend Board-approved health care; or**

**(c) the severity of the disability resulting from the worker's compensable personal injury, occupational disease or mental disorder temporarily prevents the worker from being able to personally provide dependant care.**

### 6.2 Amounts Payable

**The Board pays a reasonable amount for dependant care as a subsistence allowance to eligible workers where the costs exceed the costs the worker normally incurred prior to the compensable personal injury, occupational disease or mental disorder.**

**The Board pays the additional new costs above any amount the worker paid prior to the compensable personal injury, occupational disease or mental disorder. The Board does not pay additional costs that arise due to factors unrelated to the compensable personal injury, occupational disease or mental disorder.**

**When determining the amount to be paid, the Board considers reasonable community rates for the services provided and provincial government rates for dependant care subsidies.**

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| **EFFECTIVE DATE:** | **July 18, 2018** |
| **APPLICATION:** | **This Item applies to health care expenses incurred and health care provided on or after July 18, 2018.** |

WORK SAFE BC

**REHABILITATION SERVICES & CLAIMS MANUAL**

| RE: Travelling Companions and Visitors | ITEM: C10-83.20 |
|---|---|

# BACKGROUND

**1. Explanatory Notes**

**This policy provides guidance on when the Board pays transportation and/or subsistence allowances for travelling companions and visitors as a health care benefit.**

**2. The Act**

**Section 21(1):**

> **… the board may furnish or provide for the injured worker any … other care … that it may consider reasonably necessary at the time of the injury, and thereafter during the disability to cure and relieve from the effects of the injury or alleviate those effects…**

# POLICY

**1. ELIGIBILITY**

**1.1 Travelling Companions**

**A "travelling companion" is a family member or other person with a close personal attachment to a worker who accompanies a worker on Board-approved travel.**

**The Board may pay for transportation and/or a subsistence allowance for meals and accommodation for a travelling companion. In making this determination, the Board considers factors such as whether:**

**(a) it is medically necessary for a travelling companion to accompany the worker (for example, based on the nature of the compensable condition and/or the type of health care to be received, the Board determines a travelling companion is necessary);**

**(b) the travelling companion is required due to legal reasons (for example, the worker is a minor and parental consent is required to treat him or her); and/or**

**(c) the travelling companion is reasonably necessary for any other situation.**

**The Board does not pay wage loss compensation or subsistence allowances for income loss or temporary dependant care for travelling companions.**

### 1.2 Visitors

**A "visitor" is a family member or other person with a close personal attachment to a worker, who visits a worker while he or she is receiving Board-approved health care.**

**The Board may pay for transportation and/or a subsistence allowance for meals and accommodation for a visitor to visit the worker while he or she is receiving health care in a health care facility away from his or her resident community where:**

- **a worker is participating in a Board-approved health care program that requires the worker to live elsewhere than his or her residence for a period of six weeks or more. In this case, in lieu of paying for transportation and/or a subsistence allowance in respect of a visit home, the Board may pay for transportation and/or a subsistence allowance for a visitor to visit the worker for up to two nights, once every three weeks; or**

- **the Board determines that a visitor is reasonably necessary (for example, due to legal reasons).**

**The Board does not pay wage loss compensation or subsistence allowances for income loss or temporary dependant care for visitors.**

## 2. DURATION

**The Board generally pays a subsistence allowance for accommodation for a travelling companion for one night, where the Board determines that it is not reasonable for the travelling companion to return home on the same day that he or she accompanies the worker for the Board-approved health care. The Board may pay a subsistence allowance for accommodation to a travelling companion for a longer period to accompany the worker home, where the Board determines that it is medically necessary for a travelling companion to accompany the worker.**

**The Board may pay a subsistence allowance for accommodation for a visitor for one night. The Board may, where it is considered reasonably necessary, pay for a longer period in individual cases.**

## 3. AMOUNTS PAYABLE

**The Board determines the amount of transportation costs and subsistence allowances to pay for travelling companions and visitors in the same manner as it**

**does for workers, as set out in Items C10-83.00, *Transportation*, and Item C10-83.10, *Subsistence Allowances*.**

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| **EFFECTIVE DATE:** | **July 18, 2018** |
| **APPLICATION:** | **This Item applies to health care expenses incurred and health care provided on or after July 18, 2018.** |

WORK SAFE BC

REHABILITATION SERVICES & CLAIMS MANUAL

| RE: Date of Injury Transportation | ITEM: C10-83.30 |
|---|---|

# BACKGROUND

**1. Explanatory Notes**

**This policy sets out the circumstances in which employers are responsible for costs associated with the immediate conveyance and transportation of a worker to a hospital, physician or qualified practitioner for initial treatment.**

**2. The Act**

**Section 21(3):**

> **See Item C10-83.00.**

**3. *Workers Compensation Act*, Fishing Industry Regulations**

**Section 13:**

> **For the purposes of [section 21(3) of Part 1], the expense of transporting an injured [fisher] to a hospital, physician or other qualified practitioner for initial treatment shall be paid by the owner of the vessel on which the [fisher] is injured or where the vessel is chartered by the charterer of the vessel on which the [fisher] is injured or in default of payment by the vessel owner or charterer the vessel master.**

# POLICY

**An employer's obligation to provide an injured worker with immediate conveyance and transportation arises whether the work injury occurs on the employer's premises, at another worksite or wherever the need for initial treatment arises, when the worker is injured in the employer's employment.**

**Immediate conveyance and transportation for initial treatment is necessary whenever there is a sense that the worker requires immediate or urgent treatment from a hospital, physician or qualified practitioner.**

**The employer's cost of immediate conveyance and transportation may include the cost of medical equipment required to transport the worker to a health care facility.**


## REHABILITATION SERVICES & CLAIMS MANUAL

**In the event that a physician or qualified practitioner travels to the worker to provide initial treatment, the employer is responsible for any charge with respect to transportation.**

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| **EFFECTIVE DATE:** | **July 18, 2018** |
| **APPLICATION:** | **This Item applies to health care expenses incurred and health care provided on or after July 18, 2018.** |

WORK SAFE BC

REHABILITATION SERVICES & CLAIMS MANUAL

| RE: | Additional Benefits for Severely Disabled Workers | ITEM: | C10-84.00 |
|---|---|---|---|

# BACKGROUND

**1. Explanatory Notes**

**This policy sets out the additional benefits that may be available to severely disabled workers.**

**2. The Act**

**Section 16:**

> **(1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the board may take the measures and make the expenditures from the accident fund that it considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.**
>
> **. . .**
>
> **(3) The board may, where it considers it advisable, provide counselling and placement services to dependants.**

**Section 21:**

> **(1) See Item C10-72.00.**
>
> **(6) See Item C10-73.00.**

# POLICY

**1. DEFINITIONS**

**The following terms are used throughout this policy.**

**As set out in Item C10-72.00, *Health Care – Introduction*, "activities of daily living" are basic activities that are performed by individuals on a daily basis for self-care. Examples include, but are not limited to: ambulating (e.g. walking), transferring (e.g. getting from bed to chair and back), feeding, dressing, personal hygiene (e.g. bathing, grooming, bladder and bowel care), and taking medications.**

**An "informal caregiver" is a family member or friend who assists a severely disabled worker at home with his or her care and activities of daily living.**



**As set out in C10-72.00, *Health Care – Introduction*, "instrumental activities of daily living" are activities related to independent living. Examples include, but are not limited to: using a telephone, preparing meals, performing housework, shopping for groceries or personal items, managing medication, managing money, and/or driving a car.**

## 2. OBJECTIVE

**The Board may pay for various additional health care and vocational rehabilitation benefits and services to severely disabled workers. These are designed to alleviate the effects of the compensable personal injury, occupational disease or mental disorder and to assist in achieving physical, psychological, economic, social and vocational rehabilitation. The Board's goal is to assist severely disabled workers to reintegrate into the workplace, community and/or family environment.**

## 3. ELIGIBILITY

**For the purposes of this policy, a worker is considered to be a severely disabled worker if the worker has a work-related permanent disability that severely impacts mobility or function. The Board measures the level of disability by using the method of assessment under section 23(1) of the *Act.* As a general rule, the level of disability will be equal to or greater than 75% of total disability.**

**The Board may provide additional benefits and services to severely disabled workers at its discretion, and determines the worker's eligibility based on the merits of each case. The Board may review and adjust the worker's entitlement for these benefits and services:**

- **on a periodic basis; and**
- **when the Board determines that the nature and extent of the worker's circumstances or disability warrant a change in benefits.**

**In assessing a worker's eligibility for a specific benefit or service under this policy, the Board may consider:**

- **the type, severity and duration of the worker's disability;**
- **up-to-date scientific evidence and evidence-based guidelines of professional health organizations on the effectiveness of the proposed benefit or service;**
- **medical opinion or other expert professional advice from Board-approved health care providers;**

- **standards developed by the Board to ensure quality health care is provided to workers;**

- **the financial implications of the proposed benefit or service; and**

- **alternative benefits or services that may be considered more appropriate to address the impact of the worker's compensable disability or functional needs.**

**This list is by no means exhaustive, and relevant factors not listed in policy may also be considered.**

**Where a worker has a work-related severe temporary disability, or a work-related permanent disability of less than 75% total disability, the Board may consider entitlement to one or more benefits or services set out in this policy, in situations such as where:**

- **the worker has a pre-existing compensable or non-compensable condition that, when combined with the compensable disability, severely impacts the worker's mobility and function;**

- **the compensable disability severely impacts the worker's mobility and function and the worker, due to his or her personal or family situation, is unable to obtain assistance from an informal caregiver; or**

- **the compensable disability severely impacts the worker's mobility and function and the worker is not within geographical proximity to community health care services.**

## 4. ADDITIONAL BENEFITS AND SERVICES FOR SEVERELY DISABLED WORKERS

**Set out in the following sections are additional benefits and services that may be available to severely disabled workers.**

### 4.1 Personal Care Expenses and Allowances

**The Board takes the steps that it deems appropriate in order to assist severely disabled workers with their activities of daily living. The Board normally does**

this by paying actual personal care expenses or flat-rate personal care allowances.

### *4.1.1 Personal Care Expenses*

The Board may pay personal care expenses when a severely disabled worker requires extensive or specialized personal care to assist with their activities of daily living. The personal care in these situations is provided by a person who is employed with an agency or facility registered to provide health care services to a severely disabled worker. Based on the level of assistance needed by the worker, the personal care may be provided in a health care facility or in the worker's home.

The Board pays the worker's actual personal care expenses directly to the facility or agency providing the care.

### *4.1.2 Personal Care Allowances*

The Board may pay a flat-rate personal care allowance where a worker requires assistance with activities of daily living, which may be provided by an informal caregiver. The Board pays the worker's personal care allowance directly to the worker, not to the informal caregiver. The Board may supplement a personal care allowance by paying some personal care expenses where a worker needs additional personal care.

The Board suspends payment of the personal care allowance if a worker, who is in receipt of the allowance, requires care in a health care facility for more than 14 consecutive calendar days. The Board reinstates payment of the personal care allowance when the worker returns home and the informal caregiver resumes providing the worker's care.

### *4.1.3 Categories of Personal Care Allowances*

There are five categories of disability for which the Board considers paying personal care allowances:

Category 1: The worker requires minimal assistance with activities of daily living. For example, the worker has restricted mobility and needs some assistance with transferring, and/or requires some daily supervision to perform activities of daily living due to cognitive impairment and/or safety issues caused by the compensable disability. The worker, however, can feed, groom and clothe himself or herself.

Examples of compensable disabilities that might entitle a worker to a Category 1 personal care allowance include, but are not limited to:

- moderate brain injury,
- blindness or near blindness,
- multiple amputations at the wrist or ankle,
- aphasia, and
- hemiplegia.

**Category 2: The worker has restricted mobility and requires assistance with regard to bowel or bladder malfunction. The worker can feed, clothe and wash himself or herself but needs assistance in other aspects of personal care and activities of daily living.**

**An example of a compensable disability that might entitle a worker to a Category 2 personal care allowance is paraplegia with bowel and bladder functions impaired.**

**Category 3: The worker requires moderate assistance with activities of daily living. The worker requires assistance with feeding, cleansing, grooming, and dressing him or herself.**

**Examples of compensable disabilities that might entitle a worker to a Category 3 personal care allowance include, but are not limited to:**

- severe head injury resulting in brain damage to the extent that the worker is not bedridden, but is dependent upon assistance and ongoing care; and
- quadriplegia.

**Category 4: The worker is almost totally immobile and requires extensive assistance in all activities of daily living.**

**Examples of compensable disabilities that might entitle a worker to a Category 4 personal care allowance include, but are not limited to:**

- high lesion quadriplegia; and
- severe head injuries.

**Category 5: The worker is totally immobile and requires extensive assistance in all activities of daily living.**

**Examples of disabilities that might entitle a worker to a Category 5 personal care allowance include, but are not limited to:**

- high lesion quadriplegia with ventilator dependency;

- **disabilities requiring palliative care in the home;**
- **severe head injuries that require constant attendance and care; and**
- **a combination of quadriplegia and head injury.**

### *4.1.4 Personal Care Allowance Payable at Each Category*

**The Board pays each category of personal care allowance as set out below:**

| | Category 1 | Category 2 | Category 3 | Category 4 | Category 5 |
|---|---|---|---|---|---|
| **January 1, 2017 – December 31, 2017** | | | | | |
| **Daily Amount** | **$17.45** | **$29.72** | **$44.21** | **$57.25** | **$70.61** |
| **Monthly Amount** | **$525.19** | **$918.81** | **$1,327.12** | **$1,720.75** | **$2,114.89** |
| **January 1, 2018 – December 31, 2018** | | | | | |
| **Daily Amount** | **$17.69** | **$30.13** | **$44.83** | **$58.05** | **$71.59** |
| **Monthly Amount** | **$532.51** | **$931.62** | **$1,345.62** | **$1,744.74** | **$2,144.38** |

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

**Effective June 30, 2002, the Board adjusts personal care allowances annually on January 1st of each year, using the percentage change in the consumer price index.**

## 4.2 Respite Care

**Severely disabled workers in receipt of a personal care allowance may qualify for respite care.**

**"Respite care" is short-term, temporary care provided to a severely disabled worker to relieve the worker's informal caregiver from providing the worker with care and assistance with his or her activities of daily living. Respite care is provided by an agency or in a facility registered to provide health care services to severely disabled workers.**

**The Board arranges for the respite care and makes payments directly to the agency or facility providing the care. The worker's personal care allowance is not suspended where the duration of the respite care is for a period of up to 14 consecutive days once each calendar year.**

## 4.3 Major Home and Vehicle Modifications

**In order to promote the mobility, accessibility, safety and self-sufficiency of severely disabled workers, the Board may provide major home and vehicle modifications as discussed below. When providing major home and vehicle modifications to severely disabled workers, the Board also applies the policy in Item C10-81.00, *Home and Vehicle Modifications*.**

**Direction by the Board and/or prior Board approval is required for any home or vehicle modifications, and any unauthorized modifications or upgrades may be at the worker's own expense.**

**Set out in the following sub-sections are details of the types of major modifications that may be available to severely disabled workers.**

### *4.3.1 Major Home Modifications*

**Major home modifications may include, but are not limited to the following:**

- **kitchen and bathroom renovations;**
- **widening doorways to accommodate a wheelchair; or**
- **purchasing and installing equipment such as an elevator, stair glide or other lift device.**

**Major home modifications that the Board does not provide include, but are not limited to, building recreational areas, workshops or exercise rooms.**

**The Board pays for major home modifications:**

- **on the worker's primary residence; and**
- **on a one-time only basis.**

**The Board may make exceptions according to the worker's individual circumstances.**

**The worker is responsible for any repair and/or maintenance costs of major home modifications that result from deliberate misuse or abuse by the worker.**

**If the Board determines that the worker's current home is not structurally suitable for major modification, the Board may contribute a sum of money towards the cost of purchasing a more accessible home. The Board's contribution is an amount up to but not exceeding the actual cost of approved modifications to the**

**worker's current home. This decision does not prohibit the Board from then modifying the new home. The Board makes a separate decision regarding entitlement to modifications to the new home.**

### *4.3.2 Major Vehicle Modifications*

**Major vehicle modifications may include, but are not limited to, such things as providing wheelchair access to a vehicle by installing a van lift or power door opener, or converting a manual vehicle to an automatic.**

**Where the Board determines that the worker does not own a vehicle that is appropriate for the required modification or if it would be more cost effective to purchase a vehicle, the Board may enter into an agreement with the worker regarding purchase of a vehicle that is more appropriate for the required modification. In these cases, the worker would contribute the value of their current vehicle and the Board would contribute an amount up to but not exceeding the difference between the worker's contribution and the cost of the new vehicle.**

**Major vehicle modifications that the Board does not pay for include, but are not limited to, optional upgrades that the Board does not consider reasonably necessary to relieve from or alleviate the effects of the compensable personal injury or occupational disease.**

**The Board generally only pays for major vehicle modifications when the worker is licensed, qualified to drive, and owns, rather than leases, the vehicle. This may include situations where the worker was licensed and owned a vehicle but, due to the nature and extent of his or her compensable disability, the worker is now transported in the vehicle by another licensed driver.**

**The Board may pay for subsequent major vehicle modifications based on the Board's assessment of the worker's need for the vehicle modification. In making this determination, the Board considers the factors regarding the appropriateness of a vehicle modification as set out in Item C10-81.00, *Home and Vehicle Modifications*. The Board only pays for major vehicle modifications to one vehicle at a time.**

**The Board pays for the repair and replacement of major vehicle modifications paid for by the Board when there is a demonstrated deficiency or deterioration in the modification so that it no longer meets the worker's needs, cannot be cost effectively repaired, or jeopardizes the worker's or other's safety.**

**The worker is responsible for any repair and/or maintenance costs of major vehicle modifications that result from deliberate misuse or abuse by the worker.**

**When the vehicle is no longer roadworthy, but the modification is still in good working order, the Board may pay the costs associated with moving the modification to a new vehicle. The Board determines whether to contribute a sum toward the purchase of the new vehicle in accordance with the following section.**

### 4.4 Vehicle Purchase

**The Board may purchase or replace a vehicle for a worker where the worker does not own a vehicle that is appropriate for modification and:**

- **is only able to use a power wheelchair;**
- **uses a manual wheelchair, but medical evidence indicates that the worker, due to an injury with upper-limb involvement or other causes resulting in a similar level of functioning, is unable to self-transfer from the wheelchair into the vehicle; or**
- **is a severely brain-injured worker with a level of disability equivalent to the level of function of a worker with an upper-limb involvement injury.**

**The Board determines the type of vehicle to purchase based on the worker's level of function.**

**A new vehicle is generally expected to remain roadworthy for at least 10 years. If the worker requests a new vehicle before 10 years on the basis that the current one is not roadworthy, the Board evaluates the request on a case-by-case basis.**

**The Board only pays to replace a worker's vehicle if there is a demonstrated deficiency or deterioration in the vehicle so that it no longer meets the worker's needs, cannot be cost effectively repaired, and/or jeopardizes the worker's or other's safety. Exceptional circumstances are considered (for example, manufacturer's defects, mileage, etc.). If the worker cannot produce regular maintenance records, the Board may pro-rate the replacement vehicle costs between the worker and the Board. In those cases where the Board pays for a replacement vehicle, the Board may take responsibility for disposal of the existing vehicle.**

**The worker is responsible for:**

- **the cost of general maintenance and repair expenses for Board-purchased vehicles, such as oil changes and emission testing, as these types of expenses would be incurred by any vehicle owner; and**

- **ensuring that the Board-purchased vehicle is appropriately insured for both basic and any necessary optional coverage. The Board does not pay these insurance premiums.**

**The Board sets these and other terms and conditions at the time the vehicle is purchased for the worker.**

**The Board may pay for the maintenance and/or repair of vehicle modifications made to the Board-purchased vehicle, which are specifically required due to the worker's compensable personal injury or occupational disease.**

**The worker is responsible for any repair and/or maintenance costs of vehicle modifications made to the Board-purchased vehicle that result from deliberate misuse or abuse by the worker.**

### 4.5 Independence and Home Maintenance Allowance

**In order to assist severely disabled workers with their instrumental activities of daily living and maintaining their primary residence, the Board may pay an independence and home maintenance allowance, over and above any personal care allowance or expenses, wage-loss payments, or permanent disability award benefits.**

**This allowance is intended for services or items such as, but not limited to, the following:**

- **assistance with shopping for groceries or personal items;**
- **housecleaning services;**
- **using a taxi service where the worker is unable to maintain/drive a personal vehicle or take public transportation;**
- **gutter cleaning;**
- **tradespersons to perform general home maintenance or repairs;**
- **snow-removal or lawn and yard maintenance service; and**
- **delivery of wood to wood-heated homes.**

**In determining whether to provide an independence and home maintenance allowance, the Board considers the following:**

- **whether the worker has demonstrated an inability to perform instrumental activities of daily living due to the compensable disability and therefore requires assistance with those tasks;**

- **whether the worker has demonstrated an inability to perform home maintenance activities that most other workers would have the physical capacity to do on their own; and**

- **whether the worker lives in and maintains his or her primary residence.**

**A worker who does not live in and/or maintain a primary residence, but owns another form of accommodation may be eligible for the allowance if the Board determines that the worker would have contributed to its maintenance had the disability not occurred.**

**In addition, a worker who lives in a health care facility, but whose spouse and/or child(ren) continue to live in the family home, may be eligible for the allowance if the Board determines that the spouse and/or child(ren) are responsible for the maintenance activities covered by the allowance.**

**Where the worker has a pre-existing disability that is non-compensable, the compensable disability must be at least half the worker's combined total disability, and be a significant factor in the worker's inability to do the activities covered by the allowance.**

**A worker's eligibility for the independence and home maintenance allowance commences as of the date the Board determines the worker has an inability to perform instrumental activities of daily living and/or perform home maintenance activities that most other workers would have the physical capacity to do on their own. This includes the date the worker begins living in a health care facility where the worker's spouse and/or child(ren) continue to live in the family home.**

**A worker's eligibility for the independence and home maintenance allowance terminates upon the death of the worker, when the worker requires long-term care in a health care facility, or when the Board determines the worker is actually able to perform instrumental activities of daily living and/or the home maintenance activities that most other workers would have the physical capacity to do on their own.**

**If the worker lives in a health care facility and the Board is providing the home maintenance allowance for the spouse or child(ren) living in the family home, the Board stops paying the allowance at the earliest of:**

- **the spouse and/or child(ren) no longer living in the family home;**

- the spouse and/or child(ren) living in the family home but no longer responsible for the maintenance activities covered by the allowance; or

- the death of the worker.

The Board adjusts the independence and home maintenance allowance annually on January 1st of each year, using the percentage change in the consumer price index.

The amount of the independence and home maintenance allowance is set out below:

| Date | Monthly Amount |
|---|---|
| January 1, 2017 – December 31, 2017 | $307.63 |
| January 1, 2018 – December 31, 2018 | $311.92 |

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

### 4.6 Extensions of Health Care Treatments and Services for Severely Disabled Workers

The Board applies the policy in Items C10-76.00, *Physicians and Qualified Practitioners*, and C10-77.00, *Other Recognized Health Care Professionals*, in determining a severely disabled worker's general entitlement to the services of a physician, qualified practitioner or other recognized health care professional.

The Board may consider it reasonable to provide routine or long-term health care to severely disabled workers, based upon the nature and extent of their compensable personal injury or occupational disease. For example, the Board may pay for physiotherapy treatments beyond the limits set out in policy.

In extending the duration of health care, the Board considers the medical evidence that the health care will provide functional, preventive, or pain management benefits.

The Board may consider it reasonable to pay for treatment by more than one other recognized health care professional at a time (for example, treatment by a physiotherapist and a massage therapist), if both types of treatment are expected to lessen the impact of the worker's compensable personal injury or occupational disease.

## 4.7 Palliative Care Benefit

**The Board, in consultation with the worker's physician, determines a worker's eligibility for a palliative care benefit. Generally the Board gives consideration to a worker for the palliative care benefit where the worker:**

- **has been diagnosed with a compensable injury or occupational disease;**
- **has a life expectancy of less than six months due to the compensable injury or occupational disease;**
- **is at or below 50% on the Palliative Performance Scale; and**
- **consents to the focus of care for the compensable injury or occupational disease being palliative rather than treatment aimed at cure.**

**Examples of items or treatments the Board may pay for as a palliative care benefit include, but are not limited to, homeopathic medicines, dietary supplements, non-prescription items and non-standard or experimental services. The Board provides these items or treatments at its discretion and pays the actual costs for them. When considering whether to pay for a specific item or treatment as a palliative care benefit, the Board gives consideration to whether the item or treatment:**

- **places the worker at greater risk than the effects of the compensable injury or occupational disease due to adverse side effects; and**
- **may be provided legally in Canada and is available from an accredited source.**

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| **EFFECTIVE DATE:** | **July 18, 2018** |
| **APPLICATION** | **This Item applies to health care expenses incurred and health care provided on or after July 18, 2018.** |

**APPENDIX B**

**Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments**

# Chapter 1
# ADDENDUM

## AMENDMENTS TO VOLUME I ON OR AFTER JUNE 30, 2002

This Addendum lists the major amendments to the policies in Volume I of the *Rehabilitation Services & Claims Manual* on or after June 30, 2002. It has been inserted for convenience only and will be updated by the Vice-President of the Policy**, Regulation** and Research Division as necessary. In some cases, the reader may be referred to the appropriate passages in Volume II.

The "resolutions" referenced in this Addendum are the "resolutions" of the former Panel of Administrators or Board of Directors, as the case may be.

| Subject | Policy or Item # | Comments |
|---|---|---|
| CPI Adjustments | Various | Except for policy item #56.50, the dollar amounts in Volume I are not updated to reflect CPI adjustments. Readers should consult the corresponding policy item in Volume II for the current amount. (Policy item #56.50 does not appear in Volume II and is therefore updated in Volume I.) |
| Criteria for Commutations | #45.00 - #45.60 | Policies amended effective October 1, 2002. Amendments apply to new claims received, all active claims awaiting an initial permanent disability award adjudication, and all active claims awaiting initial adjudication of periodic payments of compensation to a dependant of a deceased worker, on or after the effective date.<br><br>See resolution 2002/08/27-04 if more information is required. |
| Chronic Pain (or Subjective Complaints) | #22.33, #22.35, #39.01, #97.40 | Policies amended effective January 1, 2003. Amendments apply to all new claims received and all active claims awaiting an initial adjudication on or after the effective date.<br><br>See resolution 2002/11/19-04 if more information is required. |

## APPENDIX B

### Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

| Subject | Policy or Item # | Comments |
|---|---|---|
| Governance | Various consequential changes | Policies amended effective February 11, 2003 to reflect January 2, 2003 changes to the WCB's governing structure. (None of the amendments affect worker benefits.)<br><br>See resolution 2003/02/11-05 if more information is required. These amendments resulted from the Amendment Act, 2002 (Bill 49). |
| New Review/ Appeal Structure | New Chapter 13<br><br>Various consequential changes | Chapter 13 (Appeals) deleted and new Chapter 13 (Reviews and Appeals) adopted effective March 3, 2003. Certain policies continued for transitional purposes. Various consequential changes made throughout Volume I, as identified by March 3, 2003 effective date and the matters to which the effective date applies.<br><br>See resolution 2003/01/21-01 if more information is required. These amendments resulted from the Amendment Act (No. 2), 2002 (Bill 63). |
| Policy on Changing WCB Decisions | New Chapter 14<br><br>Various consequential changes | Chapter 14 (Reopenings and Reconsiderations) deleted and new Chapter 13 (Changing Previous Decisions) adopted effective March 3, 2003. Chapter applies to all decisions on and after the effective date.<br><br>Various consequential changes also made throughout Volume I, as identified by a March 3, 2003 effective date and the matters with respect to which the effective date applies.<br><br>See resolution 2002/12/17-02 if more information is required. These amendments resulted from the Amendment Act (No. 2), 2002 (Bill 63). |
| Binding Nature of Policy | #2.20, #96.10 | New policy item #2.20 adopted effective March 3, 2003. Amendments apply to all |

## APPENDIX B

### Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

| Subject | Policy or Item # | Comments |
|---|---|---|
| | | adjudication decisions made on or after the effective date.<br><br>Material also deleted from policy item #96.10 to reflect the amendments.<br><br>See resolutions 2002/12/17-02 and 2003/01/21-01 if more information is required. These amendments resulted from the Amendment Act (No. 2), 2002 (Bill 63). |
| Other Amendments Resulting from the Amendment Act (No.2), 2002 (Bill 63) | | |
| Pension Reviews | #40.30 | Policies deleted effective March 3, 2003. |
| Provisional Rates | #66.12 | Policies amended effective March 3, 2003. Policy applies to provisional rates set on or after the effective date. |
| Penalties for Failure to Report | #94.15 | Policies amended effective March 3, 2003. |
| Preliminary Determination (Formerly Interim Adjudication) | #96.21 | Policies amended effective March 3, 2003. Amendments apply to all preliminary determinations made under the policy on or after the effective date. |
| Miscellaneous | Various | Other amendments, effective March 3, 2003, include:<br><br>• removal of references to former Part 3 administrative penalty process; |

## APPENDIX B

### Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

| Subject | Policy or Item # | Comments |
|---|---|---|
| | | • amendments to reflect new wording of section 99;<br>• changes to disclosure provisions;<br>• acknowledgement of WCAT authority to order the Board to pay expenses;<br>• acknowledgement of WCAT authority to award costs; and<br>• changes to reflect the payment of interest provisions under section 258.<br><br>See resolutions 2002/12/17-02 and 2003/01/21-01 if more information is required. These amendments resulted from the Amendment Act (No. 2), 2002 (Bill 63). |
| Calculation of Lump-sum Payment or Commutation | #45.61 | Direction in policy on calculation of lump-sum payments or commutations after a review or appeal reinserted effective April 8, 2003, with appropriate changes to reflect new review/appeal structure.<br><br>See resolution 2003/04/08-01 if more information is required. |
| Compensable Consequences of Work Injuries | #22.00 | For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #22.00 of Volume II of this Manual regardless of the date of the original work injury or the further injury. |
| Further Injury or Increased Disablement Resulting from Treatment | #22.10 | For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #22.10 of Volume II of this Manual regardless of the date of the original work injury or the further injury. |
| Disablement Caused by Surgery | #22.11 | For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #22.11 of Volume II of this Manual regardless of the date of the original work injury or the further injury. |

## APPENDIX B

### Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

| Subject | Policy or Item # | Comments |
|---|---|---|
| Travelling To and From Treatment | #22.15 | For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #22.15 of Volume II of this Manual regardless of the date of the original work injury or the further injury. |
| Activities on Board Premises or at Other Premises under Board Sponsorship | #22.21 | For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #22.21 of Volume II of this Manual regardless of the date of the original work injury or the further injury. |
| Injury Caused by Worker or Employer | #111.10 | For all decisions, including appellate decisions, on or after February 1, 2004 refer to policy item #111.10 of Volume II of this Manual regardless of the date of the original work injury or the further injury. |
| Schedule B Presumption | #26.21 | For all decisions, including appellate decisions, made on or after June 1, 2004.<br><br>See resolution 2004/05/18-02 if more information is required. |
| Herniae | #15.50 | For all decisions, including appellate decisions, made on or after June 1, 2004, please refer to policy item #15.50, Herniae, in Volume II of the RSCM.<br><br>See resolution 2004/05/18-03 if more information is required. |
| Board Officers | #96.20 | For all decisions, including appellate decisions, made on or after July 2, 2004, please refer to policy item #96.20, Board Officers, in Volume II of this Manual.<br><br>See resolution 2004/06/22-03 if more information is required. |

## APPENDIX B

### Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

| Subject | Policy or Item # | Comments |
|---|---|---|
| Disability Awards Officers and Adjudicators in Disability Awards | #96.30 | For all decisions, including appellate decisions, made on or after July 2, 2004, please refer to policy item #96.30, Board Officers in Disability Awards, in Volume II of this Manual.<br><br>See resolution 2004/06/22-03 if more information is required. |
| **Health Care** | **Chapter 10 and various consequential changes** | **Health care policies in Chapter 10 of Volume I are deleted and replaced with health care policies from Chapter 10 of Volume II, with necessary modifications.**<br><br>**Items C10-72.00 through C10-75.10 are effective July 18, 2018 and apply on or after July 18, 2018.**<br>**Items C10-76.00 through C10-84.00 are effective July 18, 2018 and apply to health care expenses incurred and health care provided on or after July 18, 2018.**<br><br>**Consequential changes throughout Volume I are effective July 18, 2018.**<br><br>**See resolution 2018/07/12-03 if more information is required.** |

## APPENDIX B

### Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

# Chapter 3

## *#22.34 Alcoholism and Drug Dependency Problems*

Where it is claimed that an alcohol problem may have arisen out of and as a result of a compensable injury, the compensability of the problem is thoroughly investigated in the same manner as followed in investigating the relationship of other problems to an injury. Because of the psychological nature of the problem, this investigation would normally include a reference to a Board Psychologist. The decision on acceptability will however be made by the Claims Adjudicator.

Any pre-existing alcohol problem can be treated in the same way as any other pre-existing condition. The Claims Adjudicator will have to decide whether the claimant's problems are simply a continuation of the previous problems or have been worsened by the injury.

The above procedure would also apply if a claimant whose alcohol problems have previously been accepted by the Board seeks to re-open the claim because of further problems of this type. The request would have to be investigated and if appropriate, a reference made to a Board Psychologist, and a determination made as to whether the current problems are related to the injury and the previous problem, or to some pre-existing condition or other cause.

This policy also has general application in the adjudication of drug dependency problems. For the policy regarding the prescription of ~~narcotics and other drugs of addiction~~ **potentially addictive drugs**, reference should be made to ~~#77.30~~ **Item C10-80.00**.
For the Board's policy toward applications for compensation for alcoholism as an occupational disease, reference should be made to #32.15.

**APPENDIX B**

**Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I**
**Consequential Amendments**

## Chapter 3

# NOTES

(1) Appeal Division Decision No. 92-0743; #24.00

(2) See #13.12

(3) *Law of Workmen's Compensation*, A. Larson, 1972, Vol. I, para. 23.61

(4) See #2.23

(5) Larson, para. 25.00

(6) See #19.31

(7) See #19.31

(8) See #21.10

(9) See ~~#78.11~~ **Item C10-73.00**

(10) See #44.00

(11) See #88.54 and #115.30

(12) Ewing, J. Modern attitude toward traumatic cancer. *Arch. Path.* 19:690-728, 1935

(13) Pritchard et al. The Etiology of Osteosarcoma. *Clin. Orthoped. and Rel. Res.* 111:14-22, September 1975;
Coley, W.B. *Neoplasms of Bone.* Paul Haber Inc., 2nd ed., 1960;
Dahlin, David C. *Bone Tumours*. Charles C. Thomas, 3rd ed., 1978;
Monkman et al. Trauma and Oncogenesis. *Mayo Cl. Proc.* 49:157-163, March 1974

(14) ~~See Chapter 5~~ DELETED

(15) S.21(8)

(16) *Government Employees Compensation Act*, S.4(2)

(17) *Government Employees Compensation Act*, S.4(3)

(18) Appeal Division Decision No. 92-0743

(19) *Government Employees Compensation Act*, S.3(2)

(20) *Government Employees Compensation Act*, S.5

(21) *Government Employees Compensation Act*, S.6

## APPENDIX B

## Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

# Chapter 4

## #26.30 Disabled from Earning Full Wages at Work

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

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

There is no definition of "disability" in the Act. The phrase "disabled from earning full wages at the work at which the worker was employed" refers to the work at which the worker was regularly employed on the date he or she was disabled by the occupational disease. This means that there must be some loss of earnings from such regular employment as a result of the disabling affects of the disease, and not just an impairment of function. For example, disablement for the purposes of Section 6(1) may result from:

- an absence from work in order to recover from the disabling affects of the disease;
- an inability to work full hours at such regular employment due to the disabling affects of the disease;
- an absence from work due to a decision of the employer to exclude the worker in order to prevent the infection of others by the disease;
- the need to change jobs due to the disabling affects of the employment.

A worker who must take time off from his or her usual employment to attend medical appointments is not considered disabled by virtue of that fact alone. However, income loss payments may be made to such a worker (see ~~#83.13~~ **Item C10-83.10**).

A change of employment or lay-off from work for the purpose of precluding the onset of a disability does not amount to a disability for this purpose.
For time limits with respect to occupational disease claims see #32.55.

## APPENDIX B

## Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

# Chapter 5

*#34.11 Selective/Light Employment*

**STATEMENT OF PRINCIPLE**

Selective/light employment is a temporary work alternative, offered by an employer, that is intended to promote a worker's gradual restoration to the pre-injury level of employment. The Board supports selective/light employment as an important component of a worker's rehabilitation and recognizes the value of maintaining an injured worker's positive connection to the workplace. It has been amply demonstrated that the earlier a worker is able to safely return to productive employment following an injury, the more likely he or she is of obtaining maximum recovery.

CRITERIA

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

- While the compensable injury may temporarily disable the worker from performing his or her normal work, the worker must be capable of undertaking some form of suitable employment.

- The work must be safe for the injured worker to perform. The worker's attending physician must be apprised of the nature of the work and conclude that it will neither harm the worker nor slow recovery. Should the attending physician be unable or unwilling to provide the required advice, a Board medical advisor must make the necessary determination.

- The work must be productive. Token or demeaning tasks are considered detrimental to the worker's rehabilitation.

- Within reasonable limits, the worker must agree to the arrangement.

INTERVENTION

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

- The worker and employer are in disagreement over the terms of the return-to-work.

- There is a request for intervention by either the worker or employer.

- The Board officer adjudicating the claim considers that further inquiry is required.

## ADJUDICATION

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

Where a worker refuses to accept the offer, the Board will consider the reasons for refusal and determine if they are reasonable. In making this determination, a Board officer will give regard to the nature of the work, and the worker's physical restrictions and medical requirements. Notwithstanding, Board officers have discretion to consider additional factors or evidence relevant to the case, such as transportation (see ~~policy item #82.00~~ **Item C10-83.00**) and child-care (see ~~policy item #84A.00~~ **Item C10-83.10**).

Where a worker accepts suitable selective/light employment, benefit entitlement will be determined under Section 30 of the *Act*.

Should the Board determine that the worker's refusal is unreasonable, benefit entitlement may be determined under Section 30 of the *Act*.

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## Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

# Chapter 5

# NOTES

(1) See #34.54
(2) S.29(2)
(3) See #34.40
(4) See ~~#73.50~~ **Item C10-75.10**; ~~#78.00~~ **Item C10-73.00**
(5) See #40.00
(6) See #67.20
(7) S.30(2)
(8) See#34.60

## APPENDIX B

### Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

# Chapter 7

## #51.00 CONSUMER PRICE INDEX

Section 25(1) of the Act provides that "As of the first day of July in each year the board must determine a ratio by comparing the consumer price index for April in that year with the consumer price index for October in the preceding year; and as of each first day of January, the board must determine a similar ratio by comparing the consumer price index for October in the preceding year with the consumer price index for April in the preceding year." The ratios which the Board has determined under this provision are set out below.

| Date | Ratio |
|---|---|
| July 1, 2000 | 1.00807175 |
| January 1, 2001 | 1.01957295 |
| July 1, 2001 | 1.01570681 |
| January 1, 2002 | 1.00343643 |

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

"Consumer Price Index" means the Consumer Price Index for Canada published by Statistics Canada under the *Statistics Act* (Canada).

Prior to July 1, 1974, the *Act* provided a different method of making Consumer Price Index adjustments. (7)

Authority to approve adjustments under Section 25 has been assigned to the President.

Authority has also been assigned to the President to adjust the following amounts to reflect changes in the Consumer Price Index, using the formula set out in the applicable item of the manual:

| | |
|---|---|
| Maximum and Minimum Disfigurement Amount | #43.20 |
| Clothing Allowances | ~~#79.00~~ **C10-82.00** |
| Personal Care Allowances | ~~#80.20~~ **C10-84.00** |
| Independence and Home Maintenance Allowance | ~~#81.00~~ **C10-84.00** |
| Transportation Allowance | ~~#82.20~~ **C10-83.00** |
| Subsistence Allowances: (a) Meals | ~~#83.20~~ **C10-83.10** |
| (b) ~~Non-Residence~~ Accommodation | ~~#83.20~~**C10-83.10** |
| Transfer of Costs | #114.11 |

## APPENDIX B

## Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

# Chapter 11

### *#86.12 General Referrals*

1. Claims where medical evidence indicates that the worker will experience difficulty in returning to the pre-injury employment. This would include vocational concerns arising from an uncertain medical prognosis or lengthy period of convalescence.

2. Claims in which an occupational disease affects the worker's ability to return to prior employment.

3. Claims where the pre-injury employment is no longer available because of the length of time the worker has been on compensation.

4. Claims where a return to the pre-injury occupation with the disability would put the worker at a long-term disadvantage compared with others in that occupation.

5. Requests made by the Board officer in Disability Awards for employability assessments under policy item #40.10 and policy item #40.12 and commutation investigations under policy item #45.50.

6. Investigations for the consideration of temporary partial disability benefits under section 30 of the *Act*, as set forth in policy item #35.11.

7. Consideration for continuity of income benefits under policy item #89.11 pending assessment of a permanent disability pension.

8. Consideration for ~~Homemakers' Services~~ **Subsistence Allowances** under ~~policy item #84A.00~~ **Item C10-83.10**.

9. Consideration for Personal Care Allowances under ~~policy item #80.00~~ **Item C10-84.00**.

10. Consideration for Independence and Home Maintenance Allowances under ~~policy item #81.00~~ **Item C10-84.00**.

11. Claims where recovery or re-employment is affected by:

    (a) psychological/social problems;

    (b) emotional problems;

(c) financial stress;

(d) substance abuse; and

(e) vision/hearing problems.

**EFFECTIVE DATE:** March 3, 2003 (as to deletion of reference to pension review)
**APPLICATION:** Not applicable.

## APPENDIX B

### Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

# Chapter 11

## #88.00 PROGRAMS AND SERVICES

The programs and services offered by the Board in support of vocational rehabilitation can be implemented individually or in combination as part of an overall rehabilitation plan. The nature and extent of program sponsorship is decided in accordance with the principles set forth in #88.51.

The vocational plan is agreed to and summarized in a letter of understanding which is normally signed by the Vocational Rehabilitation Consultant, the worker, and where appropriate the employer, to acknowledge the commitments and expectations of all parties.

Wage-loss equivalency benefits provided by Vocational Rehabilitation Services are payable only when wage-loss benefits have concluded and follow the same rules with regard to the deduction of pensions. (See #69.10 to #70.30.) These benefits may apply while workers are either awaiting or undertaking specific vocational programs.

Transportation and subsistence allowances ~~and accommodation at the Board's Rehabilitation Residence, as discussed in #82.00 to #84.00,~~ may also be considered in support of vocational programs.

The sponsorship opportunities of other agencies are considered in providing integrated service delivery, but their availability does not diminish the Board's primary service and funding responsibilities.

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### Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

# Chapter 11

*#88.53 Expenditures*

When it is decided to support a formal training program related directly to the disability, the assistance provided under Section 16(1) of the Act will normally include:

1. Training allowances at wage-loss equivalency when enrolled in a full-time program.
2. Tuition fees and any necessary books, materials or equipment.
3. Travel and subsistence where appropriate ~~under #82.00 to #84.00~~.

When it is decided to support a formal training program related partly to the disability, the Board will estimate the total expenditure that would otherwise have been incurred under Section 16(1) of the Act. The worker will then be offered that amount as a contribution to the cost of the preferred program. This contribution will normally be paid by installments for the duration of the program. The installments will be subject to cost-of-living adjustments using the formula provided in Section 25 of the Act.

## APPENDIX B

## Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

# Chapter 11

## ~~#90.00 SPINAL CORD AND OTHER SEVERE INJURIES~~

~~The rehabilitation program for workers with spinal cord, and other injuries of similar severity, has the same objective as any other rehabilitation program, namely to assist the worker in achieving physical, psychological, economic, social and vocational rehabilitation. Because of the severity of these disabilities, greater assistance is required than for most other disabilities.~~

~~The assistance provided by the Board may include vehicle modifications, house renovations, Personal Care Allowances, Independence and Home Maintenance Allowances and Homemakers' Services. (See Chapter 10.) Service requirements are assessed and recommended by the Vocational Rehabilitation Consultant.~~

~~In cases where quadriplegics or paraplegics with upper limb involvement are faced with additional expenses to purchase special vehicles for transportation, the Board may approve a lump-sum payment on a "one time only" basis according to the needs of the individual.~~

## APPENDIX B

## Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

# Chapter 11

### ~~#90.10 Head Injuries~~

~~One of the Board's objectives is to assist workers who have sustained serious head injuries to successfully reintegrate into the workplace, community or family environment. Quite often these workers have significant deficits or behavioural problems which need to be overcome or controlled to avoid family conflict or institutional care.The main focus of vocational rehabilitation involvement in such cases is to help maximize the functional restoration and development of the worker.~~

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## Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

# Chapter 11

### *#91.13 Expenditures*

Sponsorship of formal training programs under Section 16(2) of the Act will normally include payment of:

1. Tuition fees and necessary books, materials or equipment.

2. Travel and subsistence ~~expenses and homemaker~~ allowances, including child care, where appropriate~~ under #82.00 to #83.20 and #84A.00~~.

3. An additional living allowance may be paid as follows:

   (a) A surviving dependent spouse who is eligible for a capital sum under #55.32 should not be expected to use that sum for maintenance while undertaking a program of training needed as a result of the worker's death. Similarly, the spouse should not be expected to draw on savings or other capital sums.

   (b) The dependent spouse should be expected to use funds provided through a monthly Board pension, Canada Pension Plan benefits, allowances from the Canada Employment and Immigration Commission, etc. to meet ordinary living expenses while completing a training program. If the spouse's income from such sources falls below the minimum weekly level determined by the Board, the Vocational Rehabilitation Consultant will normally authorize the payment of a training allowance sufficient to raise the spouse's income to the minimum. The allowance is payable to the spouse during the period required to complete the training program.

   (c) The minimum is equal to the weekly equivalent of 60% of 75% of the minimum average earnings prescribed by Section 17(3)(c) for calculating pensions payable to spouses of deceased workers. This formula is essentially the same as is set out in Section 17(3)(c) for calculating the total pension (including Canada Pension benefits) payable to an invalid spouse or spouse over 50 without children (see #55.26 and #55.31).

   (d) Whether or not a spouse's income falls below the minimum, the Vocational Rehabilitation Consultant may supplement the income of the spouse when the actual expenses incurred during the course of the program exceed what is covered by the above items.

## APPENDIX B

## Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

# Chapter 12

## #93.30 Medical Treatment and Examination

The obligations of an injured worker to undertake medical treatment and examination are discussed in ~~#78.00~~ **Item C10-73.00**.

### *#95.31 Payment of Wage-Loss without Medical Reports*

Wage-loss compensation is normally paid on the basis of medical evidence supporting a disability. This medical evidence is usually in the form of a signed medical report from a physician or a qualified practitioner.

Exceptions can be made in cases of short-term disability where the worker receives brief treatment from a first aid attendant or a hospital emergency department. If the circumstances are in all other respects acceptable, and the facts support the conclusion that the lay-off was a result of the injury, then wage-loss compensation may be paid. Normally, benefits should not be paid for periods of disability exceeding three days or in any case of occupational disease unless supported by proper medical evidence.

Exceptions can also be made in cases of longer term disability. Where there is evidence to support the existence of a disability, but there has been no receipt of a medical report and where the claim has been adjudicated and accepted, a first payment should be processed on the claim. Moreover, there must be some discretion to depart from the principle that wage-loss benefits are to be paid only on medical confirmation of disability. That confirmation may appear at the time the disability begins, some time during the disability or, in some cases, after it has ceased. The question is always whether the claimant was disabled. The best evidence of that disability is almost always medical evidence, but on some occasions, evidence from the claimant or from other sources may be sufficient to establish the existence and continuation of the disability.

In summary, if there is acceptable evidence of disability, and that evidence is clearly documented, wage-loss benefits can be paid in the absence of medical reports although these will, in almost all cases, be the most acceptable evidence.

**The Board accepts** ~~R~~**r**eports **received** from ~~Red Cross Outpost~~ nurses **in remote locations** ~~can be considered~~ as medical reports if **there is** no ~~doctor~~ **physician** ~~is~~ in the **immediate** area.

## APPENDIX B

### Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

# Chapter 12

*#98.13 Medical Examinations and Opinions*

The authority of the Board to require a worker to be medically examined is dealt with in ~~policy item #78.20~~ **Item #C10-73.00**.

The medical resources of the Board cannot be used to provide a medical opinion to anyone on request. A Board Medical Advisor will, therefore, decline to provide a medical opinion if the request does not come from someone authorized to make the request. Those authorized are officers of the Board responsible for claims decisions and other Board staff where duties require an input of medical advice. Advice to treating doctors may, however, be provided according to the judgment of the Board Medical Advisor.

A Workers' Adviser and an Employers' Adviser have access to medical opinions already on file, but have no right to require any further medical opinions to be produced.

**EFFECTIVE DATE:** March 3, 2003 (as to deletion of references to Review Board and Appeal Division)

**APPLICATION:** Not applicable.

## APPENDIX B

## Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

# Chapter 12

## #99.00 DISCLOSURE OF INFORMATION

The Workers' Compensation Board, for the purposes of administering the *Act*, collects and maintains information for the purpose of adjudication and managing claims for workers or their dependants. In order to carry out all aspects of this activity, the Board in a variety of situations discloses information contained in claim files.

Provincial legislation, known as *Freedom of Information and Protection of Privacy Act ("FIPPA")* provides access for the public to the information maintained by the Board while at the same time protecting personal privacy.

*FIPPA* differentiates among "personal information", information relating to third party business interests and other types of information in the possession of a public body such as the Board. Personal information means recorded information about an identifiable individual.

Freedom of information and protection of privacy can be competing principles in many situations. Which principle is to be paramount in any particular case is sometimes difficult to determine. Until advised otherwise by the Information and Privacy Commissioner appointed under section 37 of *FIPPA*, openness prevails as far as possible in the area of compensation services. Exceptions to access should be narrowly construed. Since claim files deal with an identifiable individual, they sometimes contain personal and sensitive information. The privacy provisions of *FIPPA* will, therefore, prevail other than for the specific exceptions contained in *FIPPA*. Examples of such exceptions include the rights in section 3(2) of a party to a proceeding to access information, or the variety of exceptions listed in section 33 such as the need to comply with the requirements of a specific Act. The *Act* requires a copy of records related to a matter under review or appeal to be provided to the parties to a review or appeal.

Section 3(2) of *FIPPA* states that the *Act* does not limit the information available by law to a party to a proceeding. A proceeding does not take place until either the worker or the employer has initiated a formal review or appeal.

Before a review or appeal is initiated, the WCB must apply *FIPPA* to requests for claim information. A request by a worker should be directed to a Manager in the appropriate Service Delivery Location. The Manager will comply with the request in accordance with the *FIPPA* rules. Before a review or appeal is initiated, an employer is not entitled to a copy of the worker's claim file. Disclosure to an employer in such circumstances, is limited to that information necessary for the adjudication or administration of the claim, that is on a "need to know" basis. Once a review or appeal has been initiated, full disclosure is available to either a worker or an employer. These disclosure rules are considered to be in accordance with *FIPPA* and the rules of natural justice.

## APPENDIX B

### Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

Requests for disclosure for information in a situation not covered by the policies in this Manual should be directed to the FIPP Department of the Board. These requests will be considered on an individual basis in accordance with *FIPPA.*

*Dispute Resolution*

A request for a review of the FIPP Department's decision by the Information and Privacy Commissioner may be made within 30 days of the date the person asking for the review is notified of the latest decision.

The Chairman, as the head of the W.C.B., has ultimate responsibility within the Board for implementation of *FIPPA* for the purposes of workers' compensation.

RELEVANT SECTIONS OF *FIPPA* HAVE BEEN REPRODUCED BELOW FOR THE CONVENIENCE OF THOSE USING THIS MANUAL.

*Section 3 Scope of this Act*

(2) This Act does not limit the information available by law to a party to a proceeding.

*Section 9 How access will be given*

(3) If the applicant has asked to examine the record under section 5(2) or if the record cannot reasonably be reproduced, the applicant must

(a) be permitted to examine the record or part of the record, or

(b) be given access in accordance with the regulations.

*Section 15 Disclosure harmful to law enforcement*

(1) The head of a public body may refuse to disclose information to an applicant if the disclosure could reasonably be expected to

(a) harm a law enforcement matter,

(c) harm the effectiveness of investigative techniques and procedures currently used, or likely to be used, in law enforcement,

(d) reveal the identity of a confidential source of law enforcement information,

(f) endanger the life or physical safety of a law enforcement officer or any other person,

(g) reveal any information relating to or used in the exercise of prosecutorial discretion,

(k) facilitate the commission of an offence under an enactment of British Columbia or Canada, or

(l) harm the security of any property or system, including a building, a vehicle, a computer system or a communications system.

*Section 19 Disclosure harmful to individual or public safety*

(1) The head of a public body may refuse to disclose to an applicant information, including personal information about the applicant, if the disclosure could reasonably be expected to

(a) threaten anyone else's safety or mental or physical health, or

(b) interfere with public safety.

(2) The head of a public body may refuse to disclose to an applicant personal information about the applicant if the disclosure could reasonably be expected to result in immediate and grave harm to the applicant's safety or mental or physical health.

*Section 22 Disclosure harmful to personal privacy*

(1) The head of a public body must refuse to disclose personal information to an applicant if the disclosure would be an unreasonable invasion of a third party's personal privacy.

(2) In determining under subsection (1) or (3) whether a disclosure of personal information constitutes an unreasonable invasion of a third party's personal privacy, the head of a public body must consider all the relevant circumstances, including whether

(c) the personal information is relevant to a fair determination of the applicant's rights,

(4) A disclosure of personal information is not an unreasonable invasion of a third party's personal privacy if

(b) there are compelling circumstances affecting anyone's health or safety and notice of disclosure is mailed to the last known address of the third party,

*Section 25 Information must be disclosed if in the public interest*

(1) Whether or not a request for access is made, the head of a public body must, without delay, disclose to the public, to an affected group of people or to an applicant, information

(a) about a risk of significant harm to the environment or to the health or safety of the public or a group of people, or

(b) the disclosure of which is, for any other reason, clearly in the public interest.

(2) Subsection (1) applies despite any other provision of this Act.

(3) Before disclosing information under subsection (1), the head of a public body must, if practicable, notify

(a) any third party to whom the information relates, and

(b) the commissioner.

(4) If it is not practicable to comply with subsection (3), the head of the public body must mail a notice of disclosure in the prescribed form

(a) to the last known address of the third party, and

(b) to the commissioner.

*Section 26 Purpose for which personal information may be collected*

No personal information may be collected by or for a public body unless

(a) the collection of that information is expressly authorized by or under an Act,

(b) that information is collected for the purposes of law enforcement, or

(c) that information relates directly to and is necessary for an operating program or activity of the public body.

## APPENDIX B

### Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

*Section 27 How personal information is to be collected*

(1) A public body must collect personal information directly from the individual the information is about unless

(a) another method of collection is authorized by

(i) that individual,

(ii) the commissioner under section 42(1)(i), or

(iii) another enactment,

*Section 29 Right to request correction of personal information*

(1) An applicant who believes there is an error or omission in his or her personal information may request the head of the public body that has the information in its custody or under its control to correct the information.

(2) If no correction is made in response to a request under subsection (1), the head of the public body must annotate the information with the correction that was requested but not made.

(3) On correcting or annotating personal information under this section, the head of the public body must notify any other public body or any third party to whom that information has been disclosed during the one year period before the correction was requested.

*Section 31 Retention of personal information*

If a public body uses an individual's personal information to make a decision that directly affects the individual, the public body must retain that information for at least one year after using it so that the individual has a reasonable opportunity to obtain access to it.

*Section 33 Disclosure of personal information*

A public body may disclose personal information only

(a) in accordance with Part 2,

(b) if the individual the information is about has identified the information and consented, in the prescribed manner, to its disclosure,

(c) for the purpose for which it was obtained or compiled or for a use consistent with that purpose (see section 34),

(d) in accordance with an enactment of British Columbia or Canada that authorizes or requires its disclosure,

(d.1) in accordance with a provision of a treaty, arrangement or agreement that

(i) authorizes or requires its disclosure, and

(ii) is made under an enactment of British Columbia or Canada,

(e) for the purpose of complying with a subpoena, warrant or order issued or made by a court, person or body with jurisdiction to compel the production of information,

(f) to an officer or employee of the public body or to a minister, if the information is necessary for the performance of the duties of, or for the protection of the health or safety of, the officer, employee or minister,

(i) for the purpose of

(i) collecting a debt or fine owing by an individual to the government of British Columbia or to a public body, or

(ii) making a payment owing by the government of British Columbia or by a public body to an individual,

(k) to a member of the Legislative Assembly who has been requested by the individual the information is about to assist in resolving a problem,

(l) to a representative of the bargaining agent who has been authorized in writing by the employee, whom the information is about, to make an enquiry,

(n) to a public body or a law enforcement agency in Canada to assist in an investigation

(i) undertaken with a view to a law enforcement proceeding, or

(ii) from which a law enforcement proceeding is likely to result,

(p) if the head of the public body determines that compelling circumstances exist that affect anyone's health or safety and if notice of disclosure is mailed to the last known address of the individual the information is about,

(q) so that the next of kin or a friend of an injured, ill or deceased individual may be contacted, or

*Section 34 Definition of consistent purposes*

(1) A use of personal information is consistent under section 32 or 33 with the purposes for which the information was obtained or compiled if the use

(a) has a reasonable and direct connection to that purpose, and

(b) is necessary for performing the statutory duties of, or for operating a legally authorized program of, the public body that uses or discloses the information.

*Section 35 Disclosure for research or statistical purposes*

A public body may disclose personal information for a research purpose, including statistical research, only if

(a) the research purpose cannot reasonably be accomplished unless that information is provided in individually identifiable form, or the research purpose has been approved by the commissioner,

(b) any record linkage is not harmful to the individuals that information is about and the benefits to be derived from the record linkage are clearly in the public interest,

(c) the head of the public body concerned has approved conditions relating to the following:

(i) security and confidentiality;

(ii) the removal or destruction of individual identifiers at the earliest reasonable time;

(iii) the prohibition of any subsequent use or disclosure of that information in individually identifiable form without the express authorization of that public body, and

(d) the person to whom that information is disclosed has signed an agreement to comply with the approved conditions, this Act and any of the public body's policies and procedures relating to the confidentiality of personal information.

## APPENDIX B

### Chapter 10, Health Care, *Rehabilitation Services & Claims Manual*, Volume I Consequential Amendments

**EFFECTIVE DATE:** March 3, 2003 (as to the provision of copies of records related to a matter under review or appeal)

**APPLICATION:** Not applicable.

## APPENDIX B

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*Relevance of F.I.P.P. to Policy Items*

Various items in the Manual deal with policies affecting disclosure or privacy. These are listed below with the appropriate sections of F.I.P.P. relevant to these policies.

| Policy Item | Description | F.I.P.P. Reference | Other Reference |
|---|---|---|---|
| 45.43 | Starting a Business | 33(b) | |
| 45.50 | Decision-Making Procedures | 33(d) | W.C. Act, Sec. 35, 86 and 96 |
| 48.20 | Money Owing in Respect of Benefits Paid by Other Agencies | 33(b) | |
| 48.22 | Welfare Payments | 33(l) | |
| 48.30 | Worker Not Supporting Dependants | 3(2) and 22(2)(c), 33(a), (c), (d), (e) and 34 | W.C. Act, Sec. 98 |
| 49.00 | Incapacity Of A Claimant | 33(d) | W.C. Act, Sec. 12 and 35(1) |
| 49.13 | Application of Section 35(5) in Cases of Temporary Disability | 33(d) | W.C. Act, Sec. 35(5) |
| 49.14 | Application of Section 35(5) in Cases of Permanent Disability | 33(d) | W.C. Act, Sec. 35(5) |
| 49.15 | Application of Section 35(5) on a Change of Circumstances | 33(d) | W.C. Act, Sec. 35(5) |
| 49.20 | Imprisonment of Worker | 33(d) | W.C. Act, Sec. 35 and 98(3) |
| 53.10 | Person to Whom Expenses are Paid | 21, 22, 33(a), (d) and 33(i)(ii) and 34 | W.C. Act, Sec. 17 |
| 58.00 | Foster-Parents | 33(d) 17(3) | W.C. Act, Sec. |
| ~~74.23~~ **C10-73.00** | Examination by the Board | 33(d) | W.C. Act, Sec. 21 |
| ~~74.50~~ **C10-73.00** | Selection of Physician or Qualified Practitioner | 33(d) | W.C. Act, Sec. 21 |
| ~~78.21~~ **C10-73.00** | Examination at the Board | 33(c), 33(d) and 33(i)(ii) | W.C. Act, Sec. 21 |
| ~~78.22~~ **C10-76.00** | Consultation with Specialists | 33(d) | W.C. Act, Sec. 21 |
| ~~78.31~~ **C10-75.00** | Adjudication of Health Care Benefits Accounts | 33(c), (d) and 33(i)(ii) | W.C. Act, Sec. 21 |
| ~~78.32~~ **C10-75.00** | Reversal of Decision on Appeal | 33(c), (d) and 33(i)(ii) | W.C. Act, Sec. 21 |
| 87.10 | Consultative Process | 33(c) and (d) | W.C. Act, Sec. 16 |
| 94.12 | What Injuries Must Be Reported | 26 and 27 | |

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| 96.22 | Suspension of Claim | 3(2), 33(c), (d) and (i)(ii) | W.C. Act, Sec. 16, 21 and Div. 4 |
| 98.13 | Medical Examinations and Opinions | 33(d) | W.C. Act, Sec. 21 |
| 98.23 | Representation | 33(d) | W.C. Act, Sec. 88 and 96 |
| 98.24 | Presence of Employer | 3(2) and 33(d) | W.C. Act, Sec. 88 and 96 |
| 98.26 | Witnesses and Other Evidence | 27 | |
| 98.27 | Cross-examination | 27 | |
| 99.10 | Disclosure of Issues Prior to Adjudication | 3(2), 33(b), (c), (d), (l) and 34 and 95 | W.C. Act, Div. 4, Sec. 90, 91 |
| 99.20 | Notification of Decisions | 3(2), 22, 33(b), (c), (d), (i) and 34 | W.C. Act, Div. 4, Sec. 95 |
| 99.21 | Notification of Right of Appeal | 3(2) | |
| 99.22 | Procedure for Handling Complaints or Inquiries About a Decision | 33(b), (d) and (i) | W.C. Act, Div. 4, Sec. 95 |
| 99.23A | Unsolicited Information — Anonymous | 15, 19(1)(a), (b) | |
| 99.23B | Unsolicited Information — Identified | 19(2), 31 and 33 | |
| 99.24 | Notification of Pension Awards | 3(2), 33(c) and (d) | W.C. Act, Div. 4, Sec. 90 and 91 |
| 99.31 | Eligibility for Disclosure | Part 2, 3(2), 22(2)(c), 33(b), (c), (d) and (l) | W.C. Act, Div. 4, Sec. 95 |
| 99.32 | Provisions of Copies of File Documents | 33(b), (d) and 75 | W.C. Act, Div. 4, Sec. 95 |
| 99.33 | Personal Inspection of Files | 9 | |
| 99.35 | Complaints Regarding File Contents | 29(3) | |
| 99.40 | Tape Recordings of Interviews | 4(1) and 33(d) | W.C. Act, Div. 4, Sec. 95 |
| 99.41 | Transcripts of Workers' Compensation Review Board Hearings | 3(2), 4(1) and 33(d) | W.C. Act, Div. 4, Sec. 95 |
| 99.50 | Disclosure to Public or Private Agencies | 33(b), (d), (e), (k), and (p) | W.C. Act, Sec. 95 |
| 99.51 | Legal Matters | 3(2), 33(d) and (e) | |
| 99.52 | Other Workers' Compensation Boards | 33(d) | W.C. Act, Sec. 8(2) |
| 99.53 | The Canada Employment and Immigration Commission | 33(b) and 33(d) | U.I. Act, Sec. 94(11) |
| 99.55 | Ministry of Social Services | 33(i)(ii) | |
| 99.56 | Police | 33(b), (n) and (q) | |
| 99.60 | Information to Other Board Departments | 25 and 33(f) | |
| 99.80 | Insurance Companies | 33(b) | |
| 99.90 | Disclosure for Research or Statistical Purposes | 34 | |
| 102.32 | Initiation of Appeal | 3(2) | |
| 102.41 | Board Files | 3(1)(b) | |
| 102.42 | Oral Hearings | 4(1) | |
| 102.50 | Referral of Review Board Findings | 3(2) | |
| 103.92 | Disclosure and the Freedom of | 33(a) and 19(2) | W.C. Act ss. 58 |

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| | | | |
|---|---|---|---|
| | Information and Protection of Privacy Act | | to 65 |
| 105.10 | Appeals to the Workers' Compensation Review Board — New Claims | 3(2) | |
| 107.10 | Distinction Between Reopening and New Claim | 3(2) | |
| 108.30 | Readjudication Within the Compensation Services Division | 3(2), 22(2)(c) and 33(d) | W.C. Act, Div. 4, Sec. 21, 90 and 91 |
| 109.10 | Workers' Advisers | 33(d) | W.C. Act, Sec. 95 |
| 109.20 | Employers' Advisers | 33(d) | W.C. Act, Sec. 95 |
| 109.30 | Ombudsman | 33(d) | Ombudsman Act, Sec. 15 |
| 111.25 | Pursuing of Subrogated Actions by the Board | 3(2) and 33(f) | |
| 111.40 | Certification to Court | 33(d) | W.C. Act, Sec. 11 |
| 113.00 | Introduction | 33(d) | W.C. Act, Div. 4, Sec. 42 and 47 |
| 113.20 | Occupational Diseases | 3(2) | |
| 114.43 | Procedure Governing Applications under Section 39(1)(e) | 3(2) | |
| 115.11 | Procedure for Applying Section 47(2) | 33(d) and 33(i) | W.C. Act, Sec. 47(2) |
| 115.31 | Injuries or Aggravations Occurring in the Course of Treatment or Rehabilitation | 3(2) | |

Section 95(1) of the *Act* provides that "Officers of the Board and persons authorized to make examinations or inquiries under this Part must not divulge or allow to be divulged, except in the performance of their duties or under the authority of the Board, information obtained by them or which has come to their knowledge in making or in connection with an examination or inquiry . . ."

It further provides:

(1.1) If information in a claim file, or in any other material pertaining to the claim of an injured or disabled worker, is disclosed for the purpose of this *Act* by an officer or employee of the Board to a person other than the worker, that person shall not disclose the information except

(a) if anyone whom the information is about has identified the information and consented, in the manner required by the Board, to its disclosure,

(b) in compliance with an enactment of British Columbia or Canada,

(c) in compliance with a subpoena, warrant or order issued or made by a court, person or body with jurisdiction to compel the production of information, or

(d) for the purpose of preparing a submission or argument for a proceeding under this Part.

(1.2) No court, tribunal or other body may admit into evidence any information that is disclosed in violation of subsection (1.1).

Every person who violates Subsection (1) of (1.1) commits an offence. (38) The maximum fine for this offence is set out in Part 1 of Appendix 6.

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# Chapter 12

## #100.00 REIMBURSEMENT OF EXPENSES

Set out below are the rules relating to the reimbursement of expenses for people attending at the Board or elsewhere in connection with claims or Review Division inquiries.

The principles relating to expenses incurred in connection with medical examinations and treatment and vocational rehabilitation programs are dealt with in ~~policy i~~**I**tem ~~#82.00~~ **C10-83.00** and ~~policy i~~**I**tem ~~#83.00~~ **C10-83.10**.

The Board may be ordered by the Workers' Compensation Appeal Tribunal to pay certain expenses. Section 7 of the *Workers Compensation Act Appeal Regulation* (B.C. Reg. 321/2002) provides that the Board may be ordered by the Workers' Compensation Appeal Tribunal to reimburse a party to an appeal under Part 4 of the *Act* for the following kinds of expenses:

- expenses associated with attending an oral hearing or otherwise participating in a proceeding, if the party is required by the Workers' Compensation Appeal Tribunal to travel to the hearing or other proceeding;
- expenses associated with obtaining or producing evidence submitted to the Workers' Compensation Appeal Tribunal; and
- expenses associated with attending an examination required under section 249(8) of the *Act*.

However, the Workers' Compensation Appeal Tribunal may not order the Board to reimburse a party's expenses where those expenses arise from a person representing the party or the attendance of a representative of the party at a hearing or other proceeding related to the appeal.

**EFFECTIVE DATE:** March 3, 2003 (as to references to the Review Division, the Workers' Compensation Appeal Tribunal and section 7 of the *Workers Compensation Act Appeal Regulation*)

**APPLICATION:** To adjudicative decisions on or after the effective date.

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# Chapter 12

## #100.10 Claimants

In addition to the specific requirements set out below, the worker must satisfy the general requirements in ~~#82.10~~ **Item C10-83.00** and ~~#83.10~~ **Item C10-83.10** for the payment of transportation and subsistence.

### *#100.13 Medical Review Panels*

On an appeal to a Medical Review Panel under Section 58(3) or (4) or a referral to a Medical Review Panel by the Board under Section 58(5), expenses will be paid regardless of the result, unless it is concluded that the worker was misleading the Board or the doctor who completed the certificate initiating the appeal. Travel warrants may be issued~~, and accommodation in the Rehabilitation Residence (40) may be offered if required~~. #100.15 applies where the worker resides outside the province.

### *#100.14 Amount of Expenses*

The amount of expenses paid is calculated in accordance with the rules set out in ~~#82.20~~ **Item C10-83.00** (transportation), ~~#83.20~~ **Item C10-83.10** (meals and accommodation) and ~~#83.13~~ **Item C10-83.10** (lost time from work where the worker is not already in receipt of temporary disability or vocational rehabilitation benefits from the Board).

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# Chapter 12

*#100.15 Worker Resides Outside the Province*

The general principle stated in ~~policy i~~**I**tem ~~#82.10~~ **C10-83.00** is that, where the Board is paying travel costs of a worker located outside the province, it will only pay the portion attributable to travel in this province. This also applies to claims and review inquiries but there are some exceptions to this principle which apply here.

Where a worker resides outside the province and is specifically requested by the Board to attend a claims inquiry or a review by the Review Division, the full cost of the trip will be paid by the Board.

Where a worker resides outside the province and appeals to a Medical Review Panel, the worker is advised that, following the receipt of the panel's certificate, the Board may decide to pay expenses for the whole journey. In reaching the decision, the Board considers the contents of the panel certificate.

If the Medical Review Panel appeal is initiated by the employer or the referral to the Medical Review Panel is made by the Board, the full costs of the journey will be paid.

**EFFECTIVE DATE:** March 3, 2003 (as to references to review)
**APPLICATION:** Not applicable.

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# Chapter 12

## #100.30 Witnesses and Interpreters

The expenses of a witness or interpreter will be paid when they have been subpoenaed or have been requested to attend by the Board.

In other cases, the expenses of an independent witness will be paid where, following the claims inquiry or review by the Review Division, it appears that it was reasonable for the claimant or employer as the case may be to have assumed, prior to the claims inquiry or review by the Review Division, that the attendance of the witness would be necessary. (If a claimant or employer intends to bring more than two witnesses, or intends to bring any witness from a distance of more than twenty-five miles, they should check first by telephone with the Board officer or the review officer, as the case may be.)

Where the expenses of a witness are payable, the amount will be the same as for a claimant. Income-loss benefits under ~~policy i~~Item ~~#83.13~~ **C10-83.10** will be paid for lost time from work. The applicable maximum and minimum will be those in effect at the time the lost time is incurred. Prior to September 1, 1992, a special witness lost earnings allowance was paid as follows:

**Witness Expenses**

| **Date** | **Amount Per Half-Day** |
|---|---|
| January 1, 1983 – December 31, 1983 | $36.96 |
| January 1, 1984 – September 30, 1989 | 40.44 |
| October 1, 1989 – February 28, 1991 | 47.00 |
| March 1, 1991 – August 31, 1992 | 49.00 |

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

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

# Chapter 12
# NOTES

(1) S.53(2)
(2) S.53(3)
(3) See #94.11
(4) *Workers' Compensation Board of British Columbia, W.C.B. News*, November – December, 1975, 4
(5) S.50, prior to repeal by S.27, *Workmen's Compensation Amendment Act*, 1974 (hereafter referred to as W.C.A., 1974)
(6) See #93.22
(7) S.55(1)
(8) S.55(4)
(9) S.52, prior to repeal by S.29, W.C.A., 1974
(10) S.55(1)
(11) S.12; See #49.00
(12) S.54(2)
(13) S.54(3)
(14) S.54(6)(b)
(15) S.54(9)
(16) See #34.40
(17) See ~~#74.10~~ **Item C10-76.00**
(18) S.56(1)(b)
(19) S.56(1)(c)
(20) S.56(5)
(21) S.56(1)(d)
~~(22) S.99~~ **Deleted**
(23) See Chapter 16
(24) See #112.30; #113.30
(25) See ~~#73.54~~ **Item C10-72.00**
(26) See #34.40
(27) *Workers' Compensation Board of British Columbia, W.C.B. News Bulletin*, September – October, 1973
(28) S.5(4); See #14.10
(29) S.6(3); See #26.21
(30) S.6(11); See #29.50
(31) See #95.10
(32) See #97.10
(33) See ~~#74.60~~ **Item C10-73.00**
(34) S.88(2)
(35) S.88(4)
(36) S.88(5)
(37) S.21, *Evidence Act*

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(38) S.95(2)
~~(39) See #103.00~~ **Deleted**
~~(40) See #84.00~~ **Deleted**
(41) See#48.10

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# Chapter 16

## #112.00 INJURIES OCCURRING OUTSIDE THE PROVINCE

Section 5(1) provides in part that compensation is payable where ". . . personal injury or death arising out of and in the course of the employment is caused to a worker . . ." It places no limitation on the place of injury. On the face of it, it might be held to apply to all employment injuries, whether they occur inside or outside the province. The Board has, however, concluded that the section could not be intended to have such a broad effect. The *Workers Compensation Act* only applies to injuries occurring outside the province where its provisions expressly provide for this, or do so by necessary implication. There are two main situations that have to be considered which are discussed in #112.10 and #112.20.

The payment of health care benefits for costs incurred outside the province is discussed in ~~#73.50~~ **Item C10-75.10**.

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# Chapter 17

*#115.31 Injuries or Aggravations Occurring in the Course of Treatment or Rehabilitation*

Where there is an aggravation of an injury or a subsequent injury arising out of treatment for the primary injury, and the aggravation or subsequent injury is acceptable on the claim, compensation costs resulting from this secondary problem will be charged in the usual way. Exclusion from the employer's experience rating will only occur where:

1. the original injury was one that would not have been expected to result in death or permanent disability, and

2. the aggravation or subsequent injury occurred beyond the operations of the employer, and if the worker required transportation to a hospital or other place of medical treatment, after the employer had fulfilled the obligations under section 21(3) (see ~~policy i~~**I**tem ~~#82.40~~ **C10-83.30**), and

3. the aggravation or subsequent injury resulted in permanent disability or death.

The application of relief is limited to the pension reserve established for a fatality or permanent disability.

Consideration is automatically given by the Board officer to excluding the costs from experience rating in these cases. No request from the employer is required. The employer will be advised of the decision in writing and of the relevant review and/or appeal rights.

**EFFECTIVE DATE:** March 3, 2003 (as to the deletion of references to the Review Division and the Appeal Division)
**APPLICATION:** Not applicable.

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## Appendix 6
## APPENDIX 6

# MAXIMUM FINES FOR COMMITTING OFFENCES UNDER THE *ACT*

**Part 1 – Offences for which No Other Punishment is Provided – #47.20, ~~#74.10~~ C10-76.00, #94.15, #95.30, #98.12, #99.00**

Section 77(2) provides that "Every person who commits an offence under this Act for which no other punishment has been provided is liable on conviction to a fine not exceeding . . ." the amount set out below.

| Date | | | Amount |
|---|---|---|---|
| July 1, 2000 | – | December 31, 2000 | $3,905.51 |
| January 1, 2001 | – | June 30, 2001 | 3,981.95 |
| July 1, 2001 | – | December 31, 2001 | 4,044.49 |
| January 1, 2002 | – | June 30, 2002 | 4,058.39 |

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

**Part 2 – Maximum Fine for Discouraging Worker from Reporting to Board – Section 13(2) – #94.20**

| Date | | | Employer | Supervisor |
|---|---|---|---|---|
| January 1, 1998 | – | June 30, 1998 | $18,745.52 | $3,749.15 |
| July 1, 1998 | – | December 31, 1998 | 18,815.01 | 3,763.05 |
| January 1, 1999 | – | June 30, 1999 | 18,936.62 | 3,787.37 |
| July 1, 1999 | – | December 31, 1999 | 19,127.72 | 3,825.59 |

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

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**Part 3 – Maximum Fine for Obstructing Board in Investigation – Section 71(8) – #98.11**

| Date | | | Maximum Amount |
|---|---|---|---|
| July 1, 1998 | – | December 31, 1998 | $18,815.01 |
| January 1, 1999 | – | June 30, 1999 | 18,936.62 |
| July 1, 1999 | – | December 31, 1999 | 19,127.72 |

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